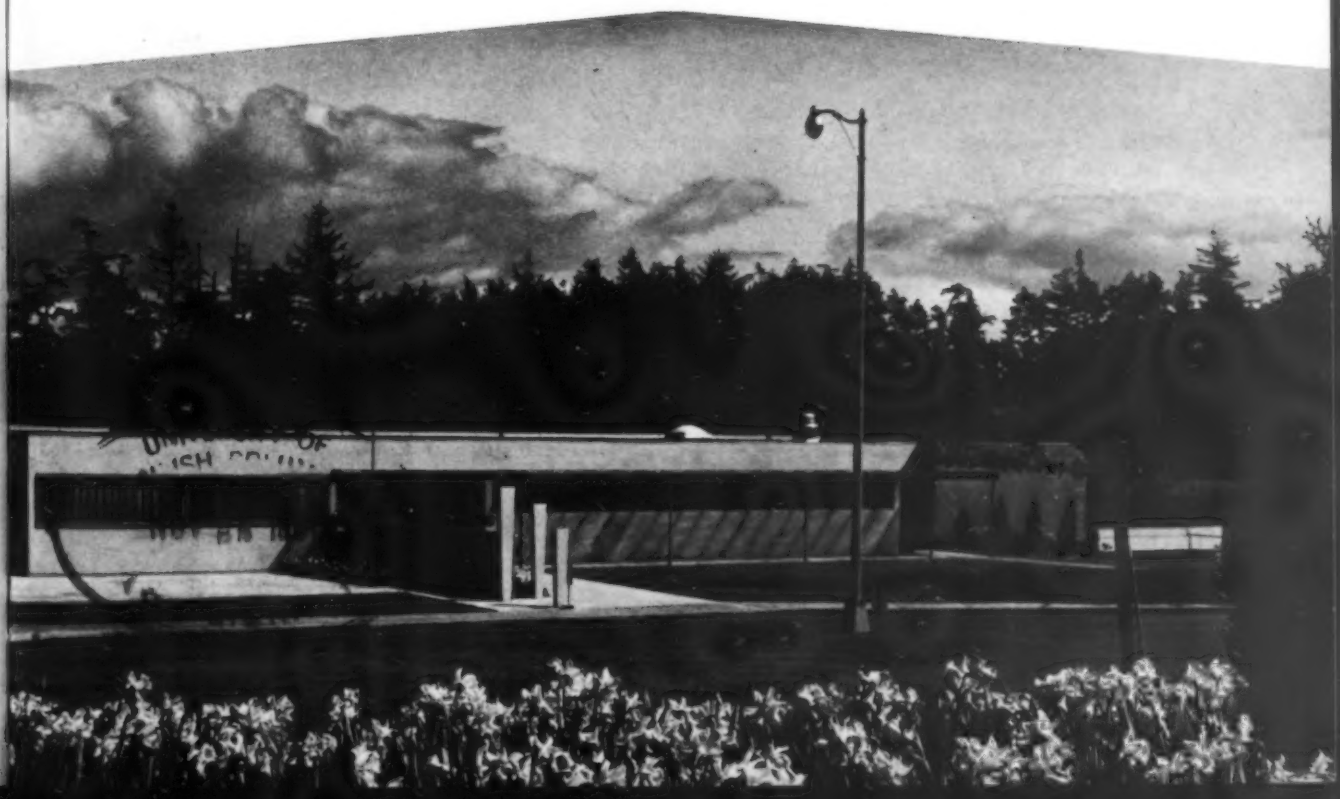
NOVEMBER, 1961

Journal of The Canadian Hospital Association

Canadian Hospital



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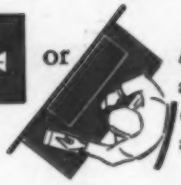

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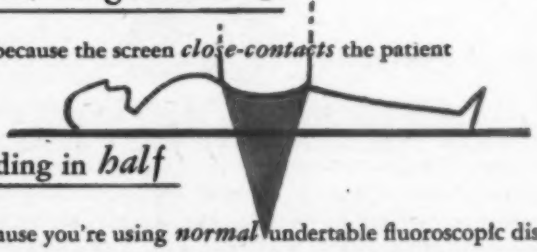

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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

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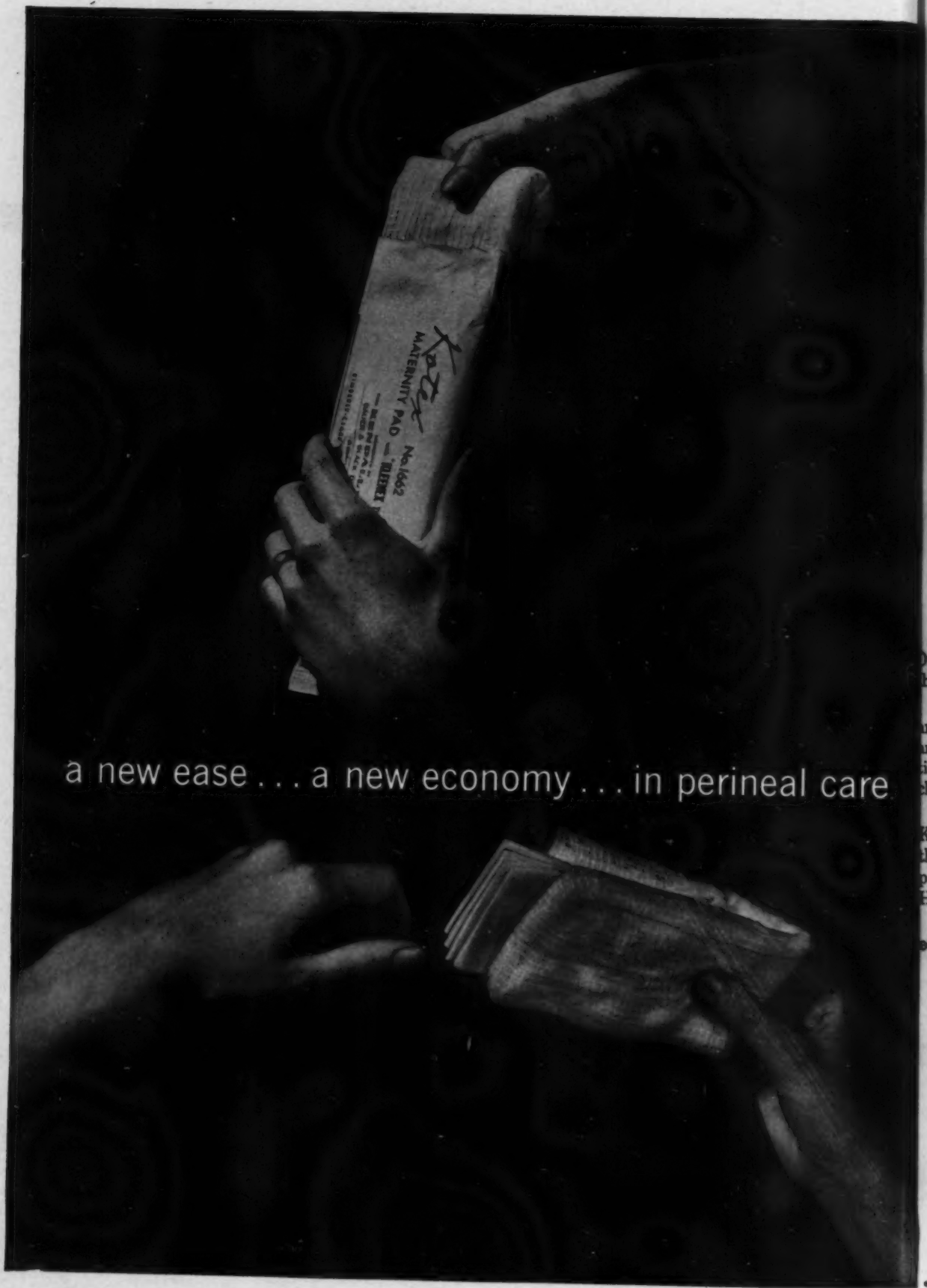
CCAB

Contents

November, 1961, Volume 38, No 11

Cover picture—Main entrance, Queen Alexandra Solarium for Crippled Children, Victoria, B.C.

Subscription rates: $5.00 a year first subscription; each additional one $2.50 — in Canada, United States and Great Britain. The rate to other countries $5.50 a year.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a new ease . . . a new economy . . . in perineal care

Now... from Curity

New Kotex*-Kleenex* pre-pack provides new convenience in self-care

Super soft, extra length maternity pads... pre-packed with full-size Kleenex tissues...for complete perineal care

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Kotex-Kleenex No. 1662 individual pre-packs packed 34 doz. per case. Other hospital Kotex pads available in bulk, in bags of one doz. pre-packs, in individual pre-packs and pre-packed with 4 Curity cotton balls.

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References: (1) Block, A.: *Fortschr. Med.* **71**:202, 1953. (2) Lössl, H. J.: *München. med. Wchnschr.* (supp.) **94**:653, 1952. (3) Birkner, F.: *Wien med. Wchnschr.* ***102***:893, 1952. (4) Bass, E., & Dietrich, H.: *Deutsche med. Wchnschr.* **77**:906, 1952. (5) Schmengler, F. E., & Köster, K.: *Med. Klin.* **47**:121, 1952. (6) Kunz, A.: *Wien med. Wchnschr.* **103**:305, 1953. (7) Böning, H., & Kirch, A.: *Fortschr. Med.* **70**:351, 1952. (8) Schmidt, J.: *Medizinische* **21**:1293, 1952.

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notes about people

G. Harvey Agnew Collection

Dr. Rhodes, director, School of Hygiene, congratulates Dr. Agnew.

On October 23, a dinner and presentation, arranged by graduates and students of the diploma course in hospital administration, School of Hygiene, University of Toronto, was held at the Faculty Club, U. of T., to honour Dr. Harvey Agnew.

Dr. Agnew, who will retire from his university post next year, has been professor and director of the above course since its inception in 1948. In 1958 the graduates of the first ten classes presented him with a scroll in which they expressed their appreciation and gratitude for his leadership. On this more recent occasion, he was presented with a plaque which is to be placed in the hospital administration section of the library in the School of Hygiene, and books to be supplied will be known as the *G. Harvey Agnew Collection*. The collection is to be financed through a trust fund established with the university by the Society of Graduates in Hospital Administration. The presentation was made to Dr. Agnew by Dr. Gerald LaSalle, program director, course in hospital administration at the University of Montreal.

Among the guests present were representatives from the University of Toronto, the Kellogg Foundation, Canadian and American hospital associations, the Ontario Hospital Services Commission, Canadian Council on Hospital Accreditation, Canadian Public Health Association, the Department of National Health and Welfare, and the Association of University Programs in Hospital Administration.

Dr. Agnew's host of friends across Canada and in other countries will be happy to learn of the honour which has thus been accorded him by his students.

Sister St. Rosaline Transferred to Edmonton

Sister St. Rosaline, administrator of Scarborough General Hospital, Scarborough, Ont., has been transferred to Edmonton, Alta., to supervise the planning and building of a 500-bed hospital there.

As well as being the administrator of the Scarborough General, Sister St. Rosaline was also responsible for the building of the hospital completed in 1958 which is operated by the Sisters of Misericorde in Toronto.

Sister St. Rosaline, who comes from Montreal, earned her nursing certificates in Illinois and Wisconsin.

Chief of Ophthalmology at Toronto Western

The appointment of Dr. D'Arcy MacDonald as chief of the Department of Ophthalmology has been announced by the Toronto Western Hospital, Toronto, Ont. He succeeds Dr. Clement McCullough who has been appointed professor at the University of Toronto.

Dr. MacDonald interned at Toronto Western 20 years ago after graduating from the University of Toronto. During the war he served in the R.C.A.F. Afterwards he studied in Montreal and England where he was awarded a Diploma in Ophthalmology. He has been on the staff of Toronto Western a year and is a consultant at Sunnybrook Hospital.

Smith-Walshaw Memorial Award to M. F. Kushnir

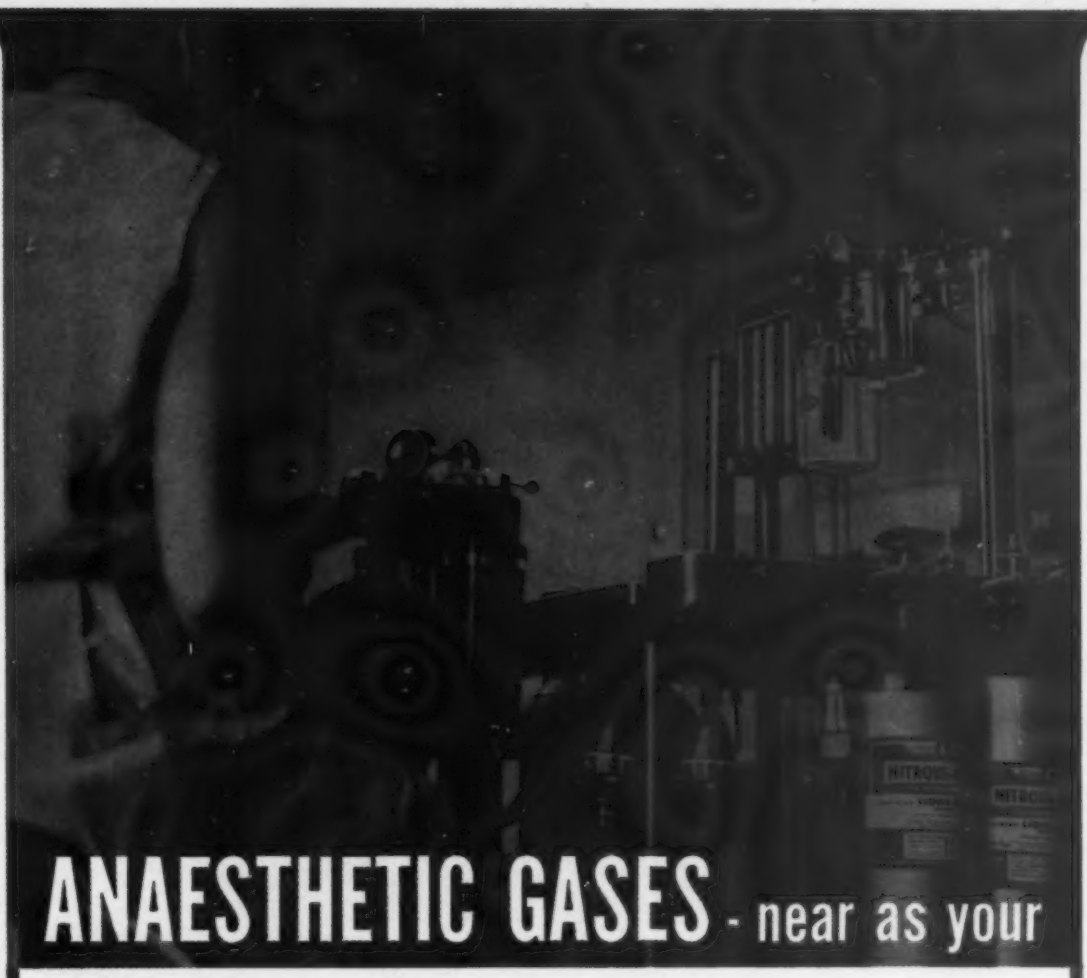
M. F. Kushnir, administrator of Canora Union Hospital, Canora, Sask., was presented with the Smith-Walshaw Memorial Award at the annual banquet of the Saskatchewan Hospital Association held last month. The award is

M. F. Kushnir

made in recognition of outstanding service and devotion to hospitals in the province and to the provincial association. It is named in honour of the late John Smith and the late E. V. Walshaw, two men who had distinguished careers in the hospital field.

In addition to being administrator, Mr. Kushnir served for a number of years on the executive of the Saskatchewan Hospital Association, completing his appointment in 1959. He has represented Saskatchewan in the House of

(continued on page 18)



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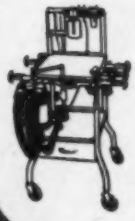

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People

(continued from page 14)

Delegates of the American Hospital Association and has been very active in programs of education for hospital administrators, nursing assistants and other personnel.

Changes on S.H.A. Staff

A. R. Thorfinnson has assumed the newly established position of assistant director at the Saskatchewan Hospital Association. Mr.

A. R. Thorfinnson

M. J. Hunchak

Thorfinnson has been a consultant in hospital administration with the Saskatchewan Department of Public Health since obtaining his diploma in hospital administration from the University of Toronto in 1960.

M. J. Hunchak has resigned from his position as administrative assistant at the association to take the position of head of the Statistical Section of the Alberta Department of Public Health, Hospital Division, Edmonton.

Canadians Serving on A.H.A. Committees

Following is the list of Canadians appointed to various committees and councils of the American Hospital Association:

L. O. Bradley, M.D., Winnipeg General Hospital, delegate-at-large to the House of Delegates;

Sister Catherine Gerard, Halifax Infirmary, Joint Committee on Paramedical Groups;

J. E. Robinson, Children's Hospital, Winnipeg, Man., Committee on Engineering and Maintenance;

Andre Schabracq, New Mount Sinai Hospital, Toronto, Ont., Committee on Purchasing, Simplification and Standardization;

W. D. Piercey, M.D., Canadian Hospital Association, Toronto, Committee on Hospital Governing Boards;

Lawrence L. Wilson, Canadian Hospital Association, Committee on Education;

J. E. Sharpe, M.D., Toronto General Hospital, Council on Professional Practice;

Stanley W. Martin, Ontario Hospital Association, Don Mills, Ont., Board of Trustees;

(concluded on page 26)

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Wherever meals are served, the customary handling of bulk jellies, condiments, dressings, syrups, etc., is often a serious source of waste.

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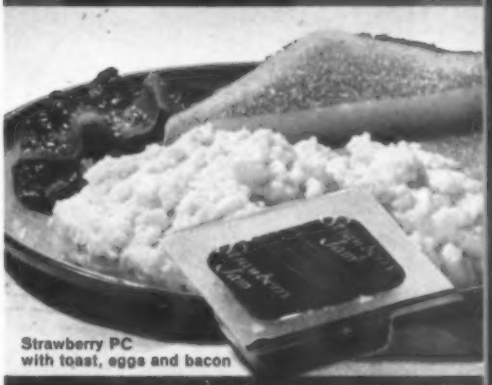
Maple Syrup PC with rice pudding


Strawberry PC with toast, eggs and bacon

Mint PC with lamb patty

Chocolate Topping PC

Orange Marmalade PC with English muffins

Simple Portion-Control System: With Kraft PCs, you eliminate a "problem area"—the time and labor of hand portioning, inaccuracy, waste and leftover losses. PCs are easy to store, inventory and serve. You control portions and costs accurately! Look over Kraft's PC family. You'll want to use every item that fits your menu.

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20 PCs per tray.....10 trays to a carton (Syrup is 5 trays per ctn.)

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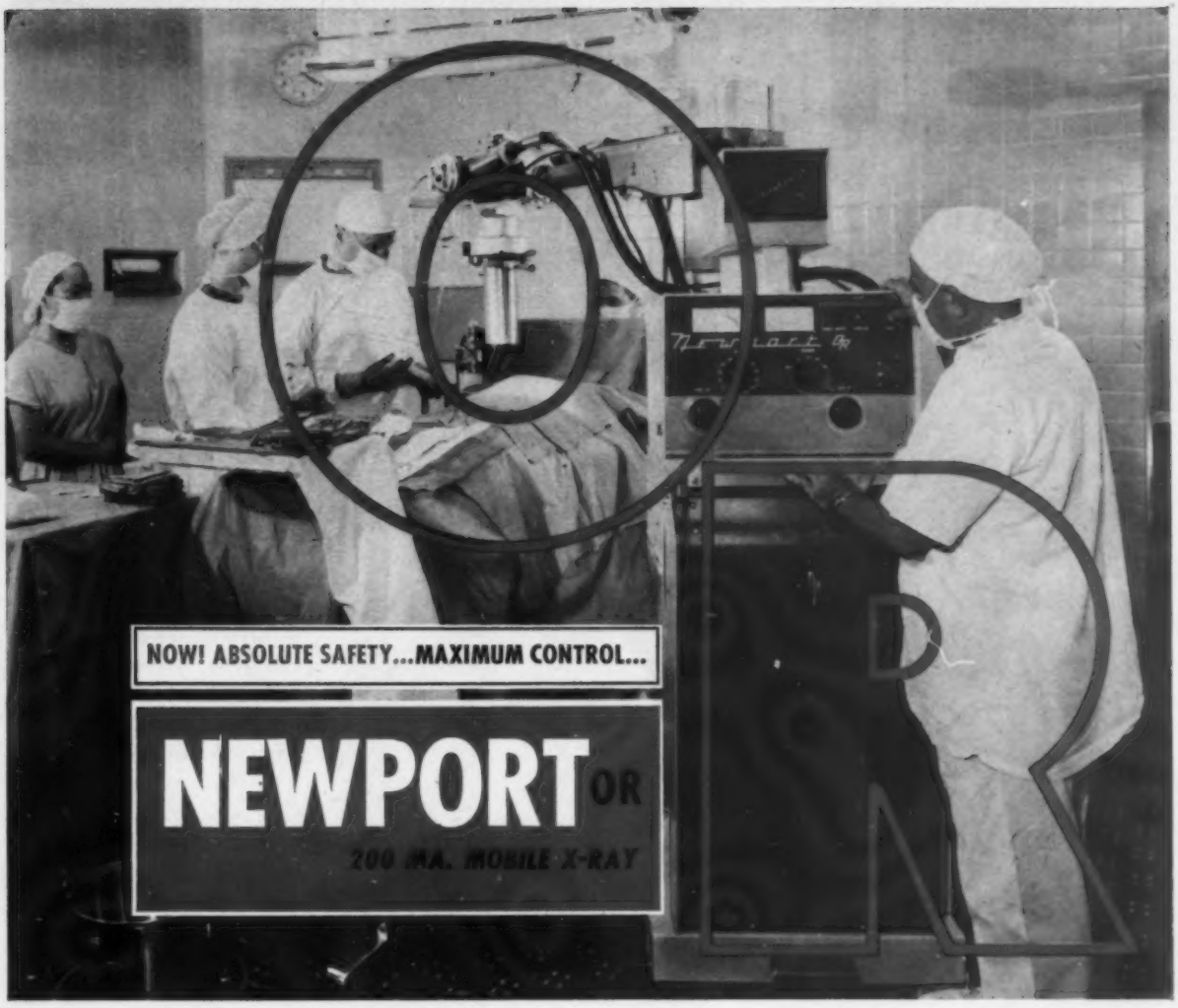

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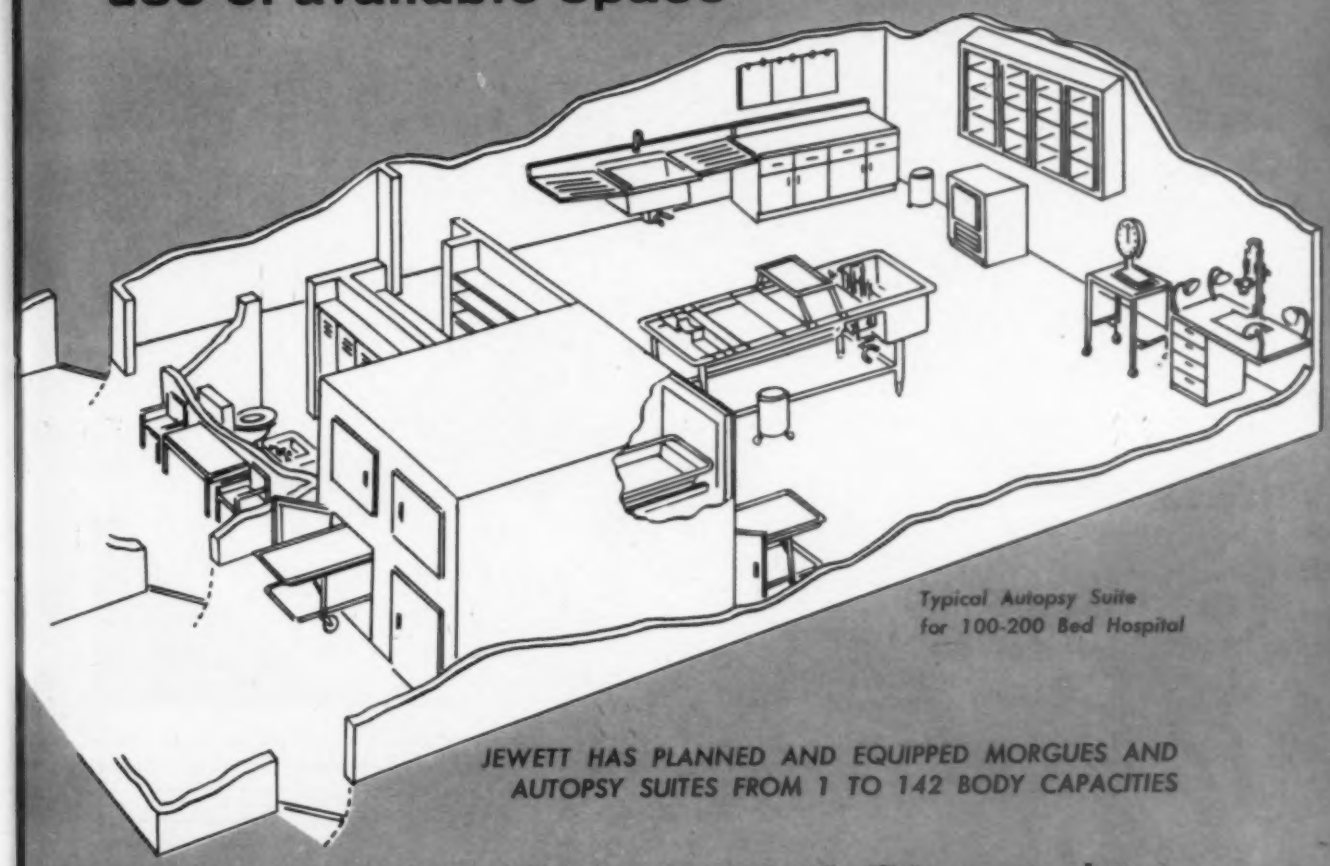

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R. F. Ingram, M.D., Montreal General Hospital, Que., Committee on Research;

Mrs. Vivien Ross, Royal Victoria Hospital, Montreal, Council on Hospital Auxiliaries; and

A. L. Swanson, M.D., University Hospital, Saskatoon, Sask., Joint Committee on Paramedical Groups.

Nursing Consultant at Dept. of National Health and Welfare

Margaret D. McLean of Kerrwood, Ont., has been appointed nursing consultant to the hospital insurance advisory staff of the Department of National Health and Welfare. Miss McLean, who has been nursing consultant for a hospital consultant firm for the past five years, will work mainly with her nursing consultant counterparts at the provincial government level.

Following training at Royal Victoria Hospital School of Nursing, Montreal, Que., Miss McLean received her B.Sc. in nursing from the University of Western Ontario, London, Ont., and her M.A. in nursing education from Columbia University, New York. Miss McLean has taught at the Toronto General Hospital School of Nursing, and later, as associate professor at University of Western Ontario.

Staff Changes at St. Boniface

Rev. Sister Boulet, assistant administrator at St. Boniface Hospital, St. Boniface, Man., is leaving the hospital for Regina, Sask.

Lawrence McKay has assumed the duties of purchasing agent at the hospital. Mr. McKay has had several years of experience in hospital purchasing, having been associated with the Port Arthur General Hospital, Port Arthur, Ont., in that capacity.

Canadian Doctor to Establish Office in Hong Kong

The Quarantine and Immigration Medical Services of the Department of National Health and Welfare have announced the posting of Dr. J. E. Hellman and Eleanor Purcell to Hong Kong to establish an office at that location. Born in Poland, Dr. Hellman received his early education there, obtaining his M.D., C.M. from McGill University, Montreal.

Miss Purcell obtained her nursing training at the Pembroke Cottage Hospital, joining the Department of National Health and Welfare in 1947 as nursing counsellor in the Civil Service Health Division. Since that time she has supervised a number of health units serving various government departments in Ottawa.

Appointment at Brantford General

Kenneth G. Muir, formerly assistant administrator of the Brantford General Hospital, Brantford, Ont., has been appointed administrator of the hospital. Mr. Muir is a 1959 graduate of the hospital organization and management course sponsored by the Canadian Hospital Association.

New Administrator at St. Ambroise

Andre Moisan has been appointed administrator of St. Ambroise Hospital in Loretteville, Que. Mr. Moisan is a graduate in industrial relations, Laval University, Quebec City. For the past eight years, he has been director of personnel at L'Hôtel-Dieu de Quebec, Quebec City.

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for refreshing,
deep hydration of the
respiratory tract

the new Croupaire T.M.

cool-vapor humidifier

Your patient recuperates in comfort while the compact **Croupaire** delivers a directional "fog stream" of cool, micronized vapor for deep hydration of the respiratory tract.

By hydrating the respiratory mucosa, soothing moisture relieves thirst and dryness so annoying to post-tonsillectomy and other post-surgical patients.

In croup and other acute respiratory disorders, the **Croupaire** moistens the sticky exudate which accumulates in the lumen of the bronchioles so it may be loosened and coughed up. A comfortable environment of cool humidity promptly eases breathing.

Croupaire operates quietly from any A.C. outlet, and provides continuous cool-vapor therapy for about 10 hours without refilling.

Croupaire therapy in your hospital will help speed recovery after anesthesia, tracheotomy, tonsillectomy and other surgical procedures; and ease breathing in croup, bronchitis, pneumonia, bronchial asthma and other respiratory disorders.

Used as a room humidifier, the **Croupaire** also helps prevent coughs and colds resulting from dried out air in winter-heated hospitals or homes.

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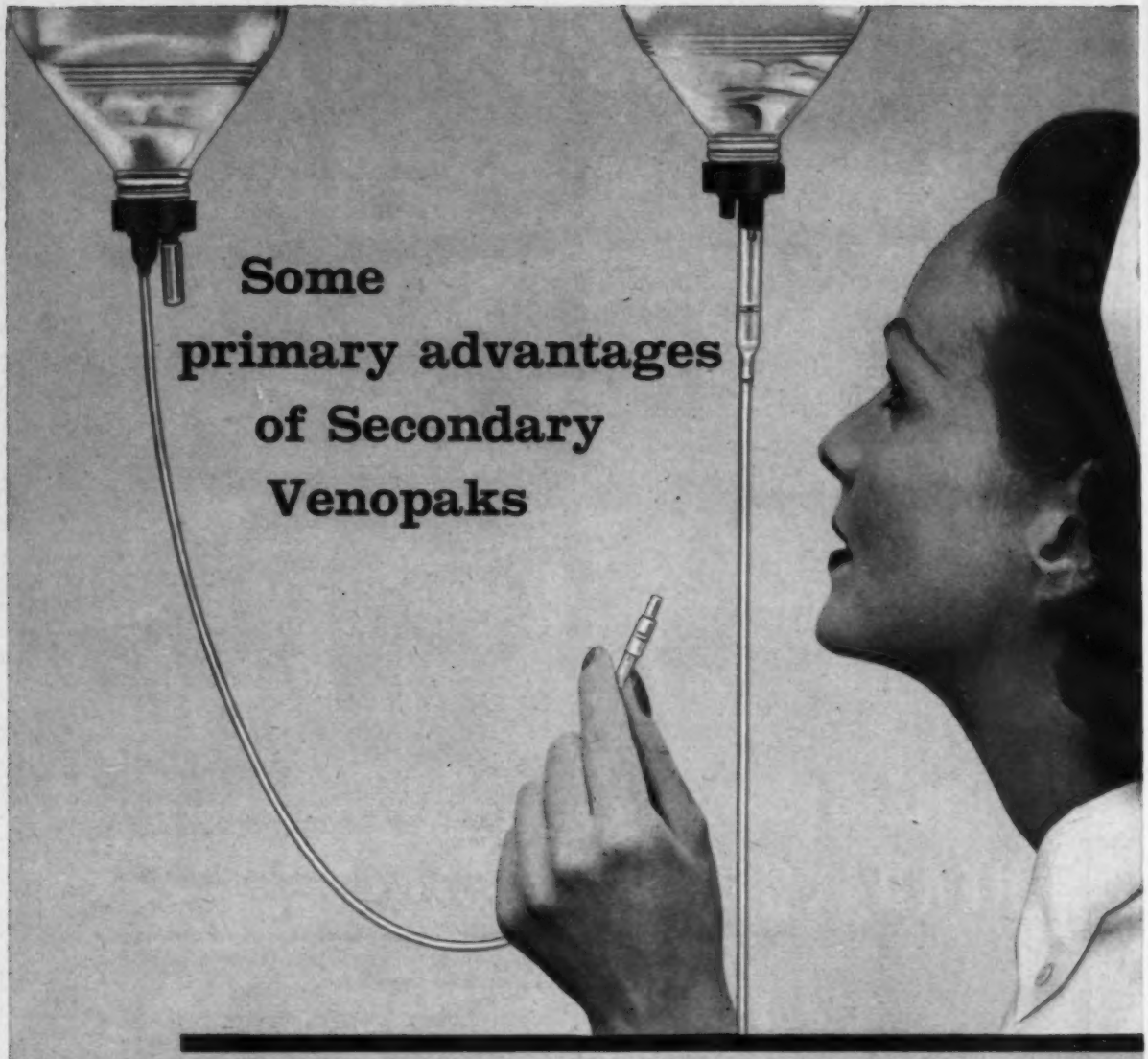

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No loss of time or of input. The primary bottle continues to flow. Rate of flow (which you can regulate by use of the clamp on the primary Venopak) is not affected.

Which fluid infuses first? If the secondary fluid has a greater specific gravity than the primary fluid, it will layer under and infuse first. Otherwise the two fluids will intermingle to some degree, and infuse simultaneously. In either event, the Secondary Venopak and container will always empty first.

Secondary Venopaks have earned more than two decades of hospital experience and approval. No administration set is faster to set up than Abbott's, none more reliable. Your Abbott man will be glad to demonstrate.

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EDITORIAL

W. Douglas Piercey, M.D.

Poison Centres and the Public

WITH the increased number of potentially dangerous drugs in use today as well as the great variety of household chemicals, there has been a corresponding increase in the number of accidental poisonings. Sadly enough, the majority of these cases are children under five years of age. In order to meet this type of emergency, many poison control centres have been established in hospitals across the country. The Food and Drug Directorate in Ottawa supplies the centres with a list of chemicals and drugs required and treatment procedures. Files are kept on thousands of drugs and their antidotes so that information can be given out or a patient treated as quickly as possible. While a physician must be in charge of the centre, naturally the pharmacist also carries a heavy responsibility.

It would seem from the literature that a very large percentage of these emergencies arise from the ingestion of internal medicines and drugs and, with new products appearing on the market constantly, it becomes increasingly difficult to keep up-to-date files on all of their characteristics and antidotes. In this connection, it is interesting to note that at its annual meeting this summer, the Canadian Pharmaceutical Association adopted two resolutions pertaining to antidotes. One is a plea that the Food and Drug Directorate disseminate more and newer information to poison centres and further, that an emergency centre be established in Ottawa, operating on a 24-hour basis, which could be reached by telephone in an emergency. The second resolution was directed to pharmaceutical manufacturers, asking that they present immediately to all pharmacists a more comprehensive list of their products, showing toxic reactions and antidotes. It asked also that the list be included in subsequent printings of specialty catalogues and that supplementary information be made available whenever a new product is introduced. Pharmacists are to be commended for their public-spirited concern that this health service be the best possible.

Because this is a specialty service, not every hospital will have a poison centre *per se;* certainly not very small units. But everyone should know where the closest poison centre is and be prepared to give that information. If you have a poison centre, then make all your publics aware of this special service you offer and invite people to ask for instructions when poisoning is suspected.

For this type of emergency there is no preventive measure except the education of both parents and children. Every health-conscious individual in the community has a duty to see that dangerous drugs do not fall into the hands of toddlers. People who work in hospitals will have many opportunities to warn patients to guard their medications when they go home.

METHODOLOGY of a study in HOSPITAL UTILIZATION

Robert Steele,
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Saskatoon, Sask.

EARLY in 1959 the board of the University Hospital, Saskatoon, Sask., requested the Department of Social and Preventive Medicine to conduct a study into the utilization of facilities provided by the hospital. This request was closely linked with the following facts: the high bed population ratio, the high per diem cost of hospital care, the medical and lay demands for additional hospital accommodation, a preliminary to planning for the University Hospital's developments, and the hope that this study might be adapted to other hospital-planning situations within the province of Saskatchewan.

In agreeing to undertake such an investigation, the department of social medicine realized the need to establish a base-line of operation in the hospital. Initially, the objectives of the study were to examine a sampling of patients admitted to hospital with a view to determining the reasons for admission; the medical care provided and by whom; the use of patients as teaching material; and the factors determining duration of stay. In a fairly non-specific study of this nature, the carrying out of a pilot study was of fundamental importance since this is a subject of great complexity and there is a lack of comparable work in other centres on which this study could be based.

With this end in view, a pilot study was conducted in the neurological service of the department of medicine during the summer months of 1959. A pro forma was designed containing a number of pertinent questions. The investigator obtained answers to the questions by visiting the wards after notification of the impending discharge of a patient. Information was transferred from the patient's records to the pro forma; the patient was then interviewed, and additional information not normally available in case records was obtained. Following this the case was discussed in more detail with the head nurse and the physician who had been in attendance on the patient. The results of this pilot study were subsequently analyzed and, although the findings could not be taken to be representative of the patients in the hospital as a whole, the study proved to be a useful exercise in determining whether the correct questions were being asked with regard to the objectives in which we were interested. It may be said that the pilot study served the following purposes: to test the suitability of the questionnaire and to direct attention to areas requiring detailed investigation; to determine the procedure for the collection of data; and to obtain an over-all picture of hospital routine.

From this exploratory study the objectives for the proposed main study were to determine:

1. The medical and non-medical reasons for admissions to the University Hospital.

2. The factors, other than those concerned solely with the medical welfare of the patient, which govern duration of hospital stay.

3. The factors concerned with mode of referral, and method and extent of consultation between hospital staff and referring doctors.

4. Patient-accommodation needs (hospital — acute and chronic, hostel).

(a) How present facilities are being used.

(b) If they may be used more effectively in any other way, and how — in our institution, in this community, and elsewhere (as reflected by patients presently referred to the University Hospital).

A pro forma was devised to explore as effectively as possible the areas covered in the objectives. It was agreed that the method of collecting data would be similar to that employed in the pilot study, *i.e.* from examination of the case records, interview with the patients and discussion with the head nurse, medical social worker and a physician or surgeon conversant with practice in the ward to which a patient belonged. An important innovation in this type of utilization study was the use of a team — consisting of the investigator, a head nurse, medical social worker and medical consultant—in each of the departments covered.

The study was designed to examine the pattern of utilization within the four major departments

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of the hospital, *i.e.* surgery, medicine, paediatrics, obstetrics and gynaecology. The special services of the hospital—psychiatry, ophthalmology and rehabilitation medicine — were excluded because of the complexities known to be associated with similar studies involving patients in these services and because it was felt that they should constitute an area of special study at some future date.

From an examination of admissions to the hospital in recent years, it was known that approximately 10,000 patients could be expected in any one year. Because of known seasonal variations in the numbers and types of cases admitted to the separate departments and to the hospital as a whole (evidence obtained by Dr. W. S. Lindsay, secretary of the University Hospital board, from examination of patterns of admission to the hospital in previous years), it was considered advisable that the survey should cover a period of one year in spite of the problems associated with conducting this type of research over a prolonged period.

A number of methods for collecting data over the year were considered and the one finally adopted to provide a 10 per cent random sampling of admissions was as follows: one day was chosen at random from each week throughout the survey year, and five cases were selected at random from the admission register for each sample day for the departments of medicine, surgery, paediatrics, obstetrics and gynaecology — giving in all 20 cases in each week and approximately 1,000 cases over the survey year. If only five cases were admitted to a department on the sample day, then all five cases were included in the survey. If less than five cases were admitted, the balance was made up by random selection from the previous day's admissions. It was necessary to draw the five cases from each sample day at random since it was observed that there is a tendency, *e.g.* in obstetrics, for "clumping" of similar admissions at particular times during a 24-hour period. (This was demonstrated in the case of false labour where patients tend to seek admission in the evening rather than delay into the early hours of the morning.) Using this method of case selection it was felt that a sample could be obtained which would be representative of all admissions to the hospital. Extensive groundwork was undertaken before the main study could be put into operation—meetings were held with the medical, nursing, medical social work and administrative staff to elicit their co-operation and to obtain access to patients and case records. This was freely given and the continuing goodwill existing between the research workers and the hospital staff was established on a sound footing by the meetings held during the planning stage of the study. The success of the study was further enhanced by the provision of space for the research assistant in the laboratory of the department of surgery so that he could easily obtain advice on procedural problems which are common in surveys of this type, particularly in the early weeks.

As a result of drafting, discussion and redrafting, a revised questionnaire was drawn up which, it was thought, would answer the questions posed in our objectives. The pro forma consisted of 80 questions, pre-coded as far as possible to allow collected data to be punched on I.B.M. cards and divided up into a number of sections to facilitate the gathering of information. The first section was designed for the recording of material readily obtainable from the abstract sheet (Saskatchewan Hospital Services Plan) of the case record. Section 2 covered the pattern of referral of the patient to the hospital; Section 3 examined the nursing care given; Section 4 — social service; Section 5 — teaching; Section 6—factors concerning admission to hospital. Additional untitled sections examined (a) whether or not the patient had been ambulant during hospital stay and (b) the final disposal of the patient, duration of stay and history of re-admission.

In order to assist in the collection of data and expert evaluations of the circumstances surrounding the patient's stay and the use made of hospital facilities, the following teams were formed: (1) head nurse, medical social worker and physician, (2) head nurse, medical social worker and surgeon, (3) head nurse, medical social worker and paediatrician, and (4) head nurse, medical social worker and obstetrician-gynaecologist.

On the day following each sample day, the five patients selected in each department were visited by a research worker who had collected basic data from the case records, *e.g.* age, sex, marital status. After describing briefly the nature of the survey and requesting the co operation of the patient (refused on one occasion only) the following questions were asked: (a) occupation of patient, husband, parent or guardian? (b) religion? (c) ethnic group? (d) does the patient speak English well enough to give a medical history? (e) does the patient live alone? (f) if not, with whom does patient live? (g) how many members are there in the patient's household? and (h) how many rooms are there in the household?

At the termination of the interview the patient was asked if he or she would be willing to discuss the case further with a medical social worker.

The names, hospital locations and provisonal diagnoses of the patients selected were then sent to the appropriate head nurses and medical social workers for the information required to complete the sections on nursing care and social service. Cards designed for the purpose were used by head nurses to record the day-to-day medical condition and nursing care. The patients were classified according to acuity of illness, and the duration in days or weeks spent in each category was noted. Provision was also made on the card for the recording of the status of the nurse providing care during each phase of illness. This information was gathered in order to establish how nursing personnel was being used according to phase of illness.

Additional questions in the section on nursing care were incorporated to establish the types of care patients were able to carry out themselves and the number of days on which they could do so, with the purpose of relating this to disease entities, age and other circumstances.

Regular meetings were held by the investigator with the head nurses and medical social workers to discuss the cases referred to them for collection of data, the evaluation of cases in each hospital service and completion of the appropriate section in the questionnaire.

Information on the use of patients for teaching and examination purposes was collected by the investigator from nursing stations, medical attendants, secretaries and bulletins from the four services. This method was recognized to be tedious and possibly unsatisfactory, but it seemed to be the best approach to the study of an area

(continued on page 92)

THE Queen Alexandra Solarium for Crippled Children, located in Victoria, B.C., is a 96-bed long-stay children's hospital designed for the treatment and care of almost any type of disease or disability except acute contagious, blind, deaf and mentally retarded (including cerebral palsy).

The original hospital was located at Mill Bay and was in operation from 1927 until this building was completed in 1958. The new hospital is placed in an ideal setting on a 60-acre site with park-like surroundings on the sea shore including a private beach. The setting allows for adequate playground facilities and provides the quiet of the countryside, yet within a few minutes of the two acute hospitals serving the Victoria area. From the wards the children can watch all ships passing in the Straits.

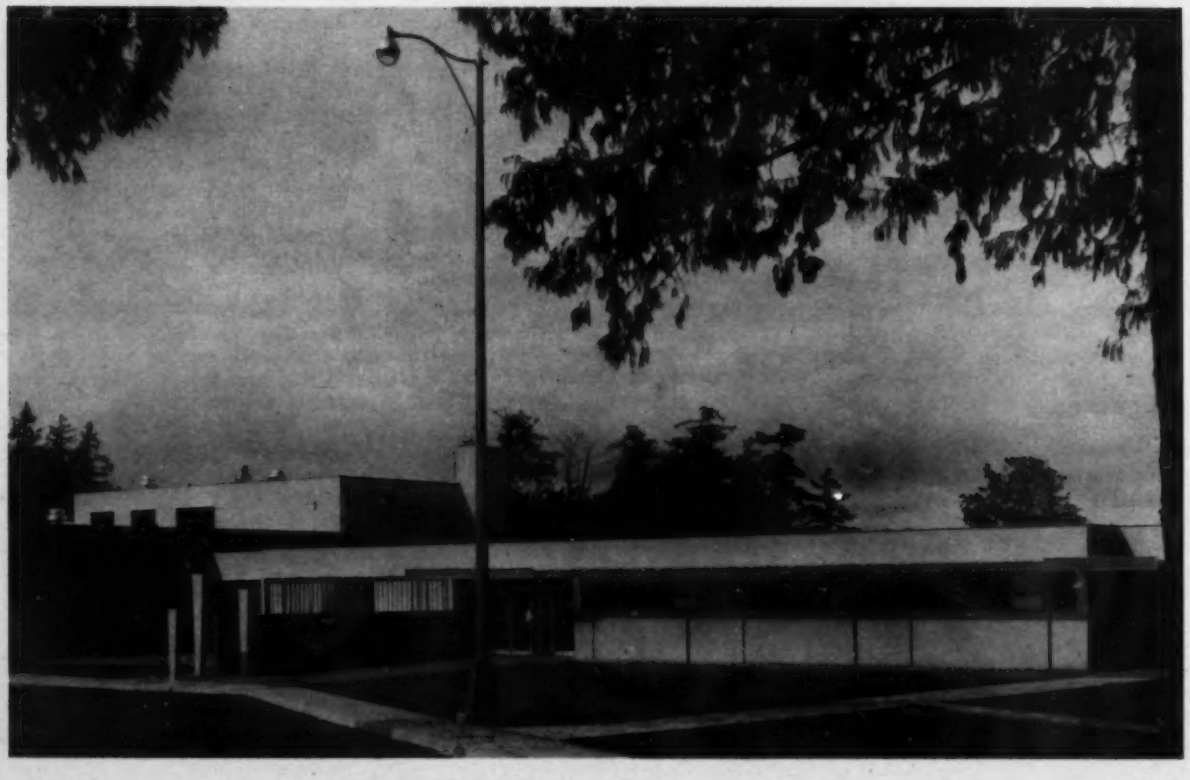
Patients are admitted from all parts of the province of British Columbia. The age of the patients ranges from the new-born to 12 years, although some children are kept beyond this age if further treatment is required. In certain cases children may be admitted who are slightly over age if some help can be given for a specific condition.

Every effort has been made to provide complete care for the patients. All surgical cases are referred to the acute hospitals in the area. This also applies to radiographic and pathological services except for minor investigations which are carried out in the hospital.

In addition to the general hospital care, a diversified program of entertainment and activities is maintained, so that children are kept occupied at all times. This program includes Sunday School, weekly film shows, stamp classes, Scout, Guide, Cub and Brownie meetings and concerts by various organizations or by the children themselves. During their stay in hospital patients also have their hair cut at proper intervals.

hospital on the sea shore

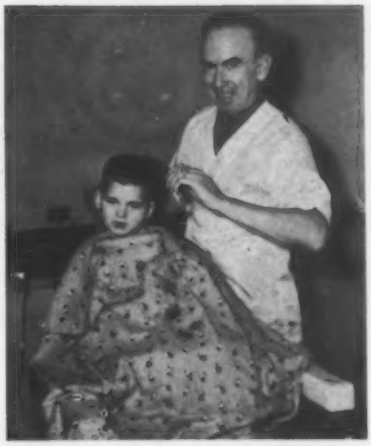
QUEEN ALEXANDRA SOLARIUM FOR CRIPPLED CHILDREN



PHYSIOTHERAPY

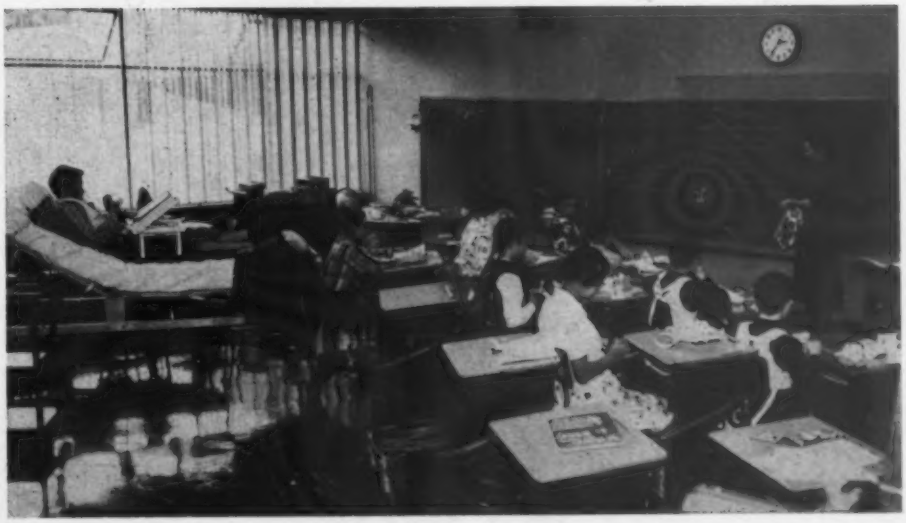
The physiotherapy department is quite extensive and includes all electrical equipment such as wax bath, infra red lamps, ultra sonic and short wave diathermy. Exercise apparatus and the usual exercising machines and other treatment apparatus is also provided. The department is designed as a flexible unit which can be set into cubicles as required or thrown open as an exercise area. A qualified physiotherapist is employed full time.

To keep small hands busy, a large and well-equipped occupational therapy department has been provided and a full-time occupational therapist is employed.



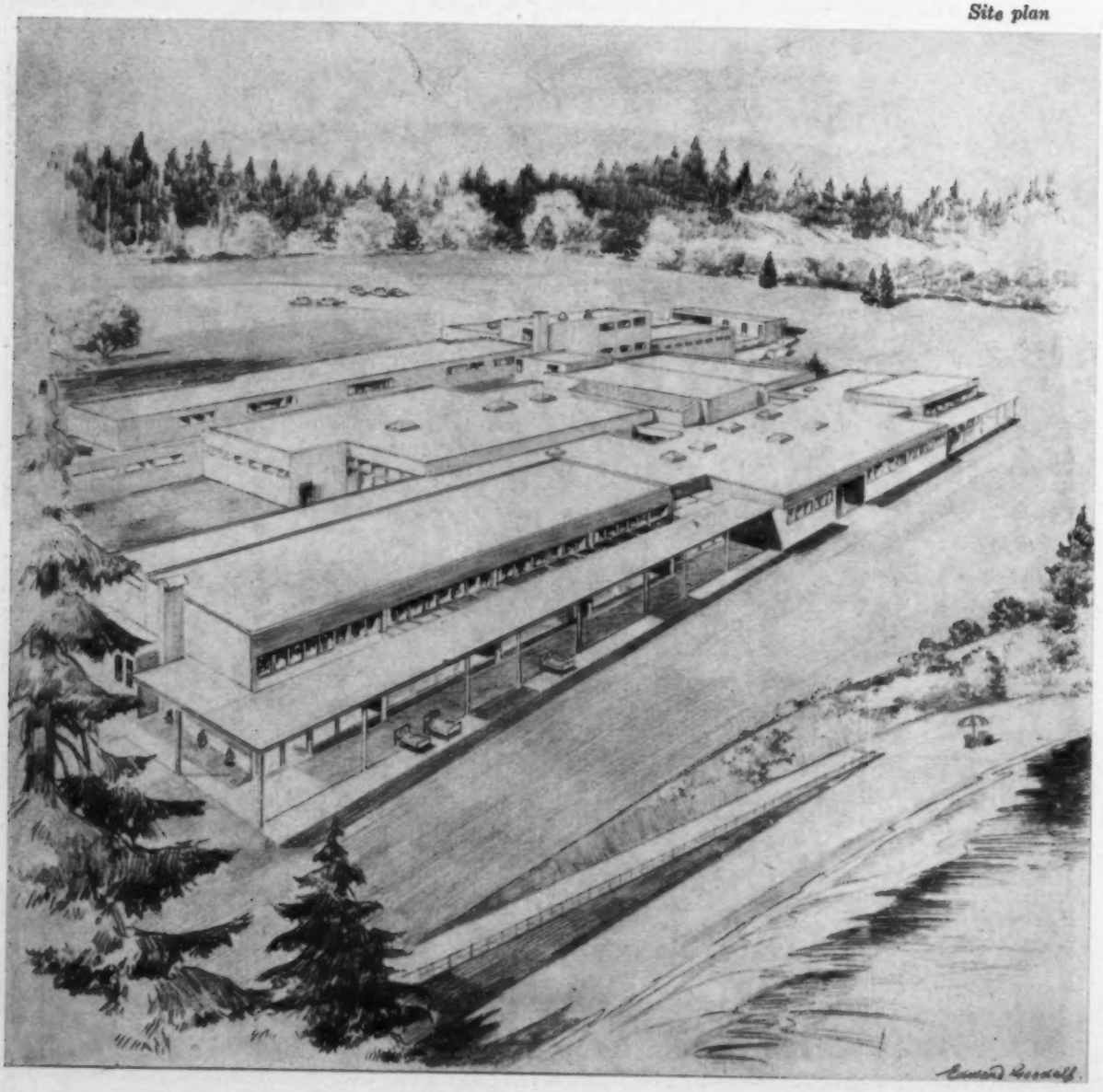
SCHOOL

In order that patients maintain normal school standards of education, two qualified teachers provide instructions during normal school hours for grades one to seven. For higher grades, it is necessary to make special arrangements for correspondence classes.



Main dining room

Site plan

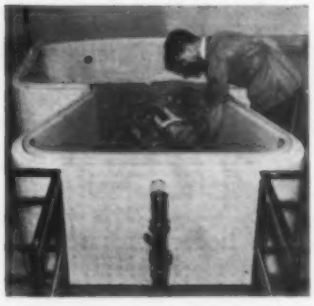


Left: Maj. Gen. G. Pearkes, now Lieutenant Governor of British Columbia, with a young patient during the opening ceremonies of the new wing in 1958. An extension to the hospital has just now been completed bringing the total number of beds to 96, although 16 of these are not used at the present.

Main kitchen

SPLINT SHOP

A well-equipped splint and brace shop is maintained within the hospital with a full-time splintmaker on staff. All splints and braces are made from raw material to ensure accurate fitting. They are adjusted from time to time to keep pace with growing children.



DENTAL SERVICE

Owing to the length of stay of most of the patients, it is necessary to arrange for the proper care of teeth and a dentist visits the hospital as often as necessary. The equipment in this department includes the new high-speed Airotor machine and a dental x-ray.

HYDROTHERAPY

Provision has been made for this treatment with a swimming pool and a Hubbard tank so that all types of hydrotherapy treatments can be given and children may also be instructed in swimming.

Patient Care and Hospital Costs and Administrative Control

Sidney Liswood, M.P.H., F.A.C.H.A.
and
Abraham J. Bohnen, B.A., B.Paed.

WITH increasing frequency we hear and read the wistful hope that hospitals should provide a higher quality of patient care, and at the same time reduce, or at least maintain, an existing cost structure. It is time that all of us who are concerned realize and accept the fact that these objectives are inconsistent and that the exceptions only serve to prove the rule. If we are to make available to the public, who come to us for care and treatment, the most modern physical plant with its increasing complexity of electronic equipment; if what medical and the allied sciences have conceived are to be provided for the patient; if the increasing demands of labour for higher pay and more fringe benefits; if all of these are to be met, then the public must be expected to pay the cost involved. There is no peculiar alchemy which will permit all of these things to be accomplished and, at the same time, stop the increasing cost of hospital care. Hospitals have a right to expect this understanding from the public and from official organizations. Hospitals also have the responsibility of assuring the public and its representatives by demonstration that their costs are scrutinized and controlled and that we are spending our money wisely and well. To do this we are obliged to show that we employ effective control measures. This is neither unreasonable nor difficult.

No one will deny that it is a great responsibility to provide society with a free, independent, high quality system of hospitals. Inherent in this is the fact that the cost of providing complex hospital care will continue to rise — both capital costs as well as operating costs. These increased costs can reflect an increased quality and quantity of care only if they are controlled to eliminate waste of time, effort, material, and abuse of service.

It should be emphasized, however, that our approach must be our belief in a specific philosophy of hospital administration. If the administrator, and this term is used in its generic sense to include department heads and chiefs of service, is impatient with waste of time, effort and material, then he will also undoubtedly demonstrate an equal impatience with mediocrity in medical care and in the total care of the patient. Therefore, we must first accept a positive attitude towards hospital administration — that of the first rate, and resolve to be satisfied with nothing less. If we accept this, then all things will fall into place. In essence, we shall have the highest quality of patient care provided economically and efficiently, and after all, this is our rationale for existence.

What Does Industry Have to Offer?

It is frequently suggested that hospitals should look to industry for examples of cost control, automation and efficiency of operation in general. The analogy between hospitals and industry is at best limited, if for no other reason than the fact that the hospital, unlike industry, is a service organization. This is not to say that we cannot learn much from industrial organizations which have established certain methods, criteria and concepts resulting in efficient organization. Industry can in turn learn from hospitals, and in the process become more humane.

As we attempt to transfer these concepts to the hospitals, we find the total area of control significantly circumscribed. Neither the value nor the price factor may be subjected to the same rigorous methods of control that may be applied in industry. The reasons for this are obvious. The hospital treats patients whose illnesses cover a very wide range and whose care calls into play varying

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amounts of materials (food, drugs, medical and surgical supplies), professional skills (physicians, nurses and technicians), and overhead costs. In addition, treatment is carried on under varying circumstances, in bed as an in-patient, in an out-patient department, in an emergency ward, or for the private ambulatory patient who comes to the hospital for diagnostic services and treatment.

Despite the foregoing limitations of control, we are aware that by breaking down the total care of the patient into certain specialized functions, we can arrive at units of productivity which may be utilized for control purposes as, for example:

Pharmacy — number of prescriptions dispensed

Operating room—number of operations performed, using a weighted number of units for grading *very minor, minor* and *major* operations

Laboratory—number of units performed

Similar units of productivity may be worked out for other cost centres of the hospital.

Budgeting

Notwithstanding the fact that it is frequently considered a tedious burden by many of us, one of the important concomitants of the Ontario Hospital Services Commission was the requirement that all hospitals submit budgets to the Commission for approval. Budgeting itself is perhaps the best of control measures, for it compels us to plan our hospital's financial future in terms of its program. As such, it serves as an empiric control device by requiring consideration of each category of expense in conjunction with the responsible department head and, when completed, provides us with guide lines for the fiscal period.

Control of Salaries and Wages

Obviously, the area of hospital costs which can be most rewarding if effectively controlled is pay-roll costs. In the past half century industry has succeeded in reducing labour costs by means of automation. In hospitals the trend has been just the opposite. About 25 years ago, labour costs in hospitals were approximately 40 to 45 per cent of total costs—today they constitute 65 to 70 per cent. The factors responsible for this are well known to hospital people and need not be emphasized again. The fact remains that, while the advances of science have helped industry reduce the man-hours needed to perform a given task in a given time, they have had exactly the opposite effect when applied to hospital work. They have brought about an increase in the number of people needed to provide a given number of hours of patient care. This is due to such factors as more complicated surgery, better post-surgical care, more complicated treatments and diagnostic procedures, as well as a reduction in the work week.

The application of automation in a service organization is limited; and when applied to direct patient care, carries the risk of impersonalizing it. Accordingly, we should expend all efforts to satisfy ourselves that the money spent on labour costs brings with it a proper return. This can be achieved by applying certain standards or indices of productivity within the hospital. This productivity index may be expressed in terms of number of units per man hour worked (it will be noted that the term used is "man-hours worked", not "man-hours paid for"). Sick leave, vacation time, time and a half for overtime—all should be eliminated in computing the man-hours worked. By experience, by consultation with department heads, by reading the literature and by comparison with the data of other hospitals, we can establish norms. When the nursing profession states that a certain number of professional and non-professional hours per patient day are necessary to provide adequate patient care, it is establishing norms. We should extend this approach to the other departments of the hospital.

The previous paragraph has dealt with man-hours worked. What consideration should be given to man hours not worked, but paid for? For example, sick leave, premiums for overtime and vacation allowances. This is an area that the hospital administrator will neglect only at his peril, since many thousands of dollars can be dissipated without justification. What kind of measures should be used to control these aspects of labour costs? The following would appear to be essential in this regard:

(a) Written policies outlining in clear and simple terms the employee entitlement in terms of sick leave, vacations and overtime.

(b) A continuously functioning system of internal checks to assure that these policies are being carried out.

(c) A methodical study of sick leave and overtime paid by the department.

Schedules should be drawn up monthly, comparing percentage sick leave hours to total hours paid by the department. The department head should be expected routinely to explain the use of overtime hours. These procedures will bring to light the "trouble spots" of the hospital so that remedial action may be taken.

Reference should also be made to two other devices which have been used in controlling personnel costs, namely position and wage-level control. When we exercise position control (the setting up of a specific card to represent each budgeted position in the hospital), we guarantee that no new unauthorized positions will be created. When we exercise wage-level control, we ensure that no individual will be hired at, or that no one's wages will be increased to, a level above that authorized by the budget. Only one person in the organization should have the authority to approve new positions or establish new salary range limits, and that is the administrator. The possibility of effecting economies by reduction of staff should always be present in the administrator's mind. Illustrations of occasions in which such reductions might be called for are:

1. A change in the treatment of certain types of illnesses. Consider, for example, the reduction in the use of basal metabolism tests and electro-shock therapy in general hospitals.

2. Introduction of automation in the accounting, dietary and housekeeping departments, as well as such professional departments as laboratory and x-ray; for example, the use of an automatic x-ray developer which processes a film in seven minutes and materially increases the productivity of the radiologist. In the laboratory, an auto-analyzer does in a few minutes what used to take a technician a half a day to do. The technicon automatically prepares tissue for examination by the pathologist, thus freeing the technician to do other work, and the automatic cell-counter makes it possible for the technician in the haematology laboratory to do a significantly greater amount of work. At this hospital, the number of laboratory units in 1960 was 47 per cent

greater than was performed in 1958. However, there has been no increase in the number of personnel, primarily due to the use of automation.

3. Changes in basic financial relationships, as between the hospital, governmental and other insuring agencies.

In the general review of staff strength in each department, it is important to emphasize that the administrator should encourage department heads to maintain a flexible and multiphasic view of their functions. The administrative departments, such as accounting, admitting, and purchasing, should not be so rigid in their outlook that they cannot visualize a merging of certain functions which might be to their mutual advantage, and at the same time, effect economies in man-hours. Similarly, one may find means of combining functions of individuals in the nursing, dietary and housekeeping departments as they come together on the nursing unit, which, if carefully planned and organized, can greatly increase the effectiveness of the personnel concerned and reduce personnel by preventing overlapping.

Control of Supplies and Expenses

When we consider the control of supplies, we shall again find the use of units of productivity helpful—the cost of raw food per meal day, or the cost of films per x-ray examination are good examples. In the dietary department one frequently encounters difficulty because the monthly reports from the accounting department generally come too late to enable the dietitian to take instant remedial action. This may be overcome by making it possible for the dietitian to keep an uncomplicated record on a day to day basis of the cost of perishable food, and by furnishing her with the cost of non-perishable food issued to her by the stores room on each requisition. She will group these costs according to a predetermined classification, such as meats, eggs, butter, et cetera, and determine the cost per meal day for each of these groups. A comparison of these costs per meal day from month to month will enable her to assess the allocation of a meal-day dollar in order to achieve the best results.

Pre-printed requisition forms and floor standards for the use of linens, as well as supplies, give the administrator and the department head a measure in effecting control. In addition, all purchase orders should be signed by the administrator or his designated representative.

To know how the drugs, medical and surgical supply costs are being incurred, the administrator must have a distribution of costs according to the area in which these supplies are being used. Mere knowledge of distribution is, of course, not enough. It must be imparted to the people responsible for this expenditure, and in a manner which will be most meaningful. In our hospital, at one meeting of head nurses, the comptroller illustrated graphically the annual cost of certain medical and surgical supplies. Items which are used in large quantities, such as thermometers, cellu-wipes, and flashlight batteries, were selected and attached to a board showing the annual cost of these items. The board, after demonstration at such a meeting, is sent to each of the floors of the hospital where it is left for a period of time so that the various personnel working on these floors are aware of the items and costs involved. This procedure is repeated from time to time.

Whatever the method used to gain the interest of head nurses, interns, department heads and other employees, information should be provided by monthly reports to each department head showing the total cost per patient day or per unit of productivity for his department and comparison should be made with predetermined standards, such as those set by the budget or the experience of previous years. Any departure from the anticipated budget should require a written explanation from the department head. To be effective, the submission of these reports should be accompanied by periodic discussions so that corrective measures may be taken wherever they are indicated.

Medical Staff Participation

Difficulty of control is further increased by the fact that the services to be rendered to the patient are initiated by a group of people who are not under the direct control of the hospital administration, namely, the physicians. Therefore, boards of directors and administrators are frequently reluctant to question the kind and amount of treatment ordered. In other words, while having the legal responsibility for patient care, they delegate control over its quality and quantity to the physician. However, implicit in this delegation is the right to review. Indeed, the obligation is to do so. Hospital management is responsible for so organizing its medical staff that control measures are employed and results reported regularly concerning the quality of medical care, as well as the excessive use of the hospital's facilities and services and the prescribing of drugs. No physician has a vested right in these, and, with the co-operation of the individual physician, this can be done without infringing upon his right to care for his patients. Understanding is the result of mutual trust and effective communication. By keeping the individual physician informed, not only of the hospital's problems, but also of its program, and by his participation through committee activity in actual administration of the hospital, we will tend to secure his co-operation in effecting controls. He will soon realize that these controls are in the best interest of himself and his patients.

Length of Patient Stay

Since the insurance program has come into effect there has been an increase in the length of patient stay, and this has occurred at a time when the demand for hospitalization has increased, primarily because of the availability of insurance. The only way that this demand can be met is either by reducing the length of stay and making it possible to serve a greater number of people, or by providing more hospital beds. Quite obviously, from a financial standpoint, the former is preferable. However, we feel that the length of stay of patients will continue to increase as our population ages and as degenerative diseases increasingly characterize the greater proportion of those patients admitted to our hospitals for active treatment, particularly if breakthroughs occur in the treatment of such diseases as cancer and heart disease. Such break-throughs will bring with them long and protracted medical and hospital care requiring active treatment. It is interesting to note that the length of stay in such centres as New York City, as reported by the United Hospital Fund, and in other metropolitan areas in the United States, has increased even in the absence of governmental hospital insurance programs. However, a study of the average length of stay for specific disease entities

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ONTARIO'S Administrative Audit Service

Bernard McCarthy
Toronto, Ont.

IN almost every field of activity those in charge are continually analyzing and reviewing their operations with the goal of improvement in mind. Frequently someone from outside the organization is invited to assist in such a review. This is often the case with governments and other public agencies which produce a service rather than a tangible product, and which do so under conditions of monopoly rather than competition.

An example of such a review is the special committee established recently by the premier of Ontario to review the organization of the government, with particular emphasis on administrative and procedural elements. The terms of this committee were: "To examine into the administrative and executive problems of the government of Ontario and all divisions of the provincial service and to examine into the relationships of Boards and Commissions to the government and the legislature". More recently a similar committee was set up by Prime Minister Diefenbaker to review the organization and operation of that mammoth enterprise known as the federal government. Similar reviews have been suggested for municipal governments, particularly since corruption was recently discovered in a few of the municipalities making up Metropolitan Toronto. These would, of course, be in addition to the annual financial audits already in existence. The purpose of such reviews is to stimulate more efficient local government and restore public confidence in government.

In many ways the product of the hospital, patient care, is similar to government services: it cannot be precisely measured and in addition it is offered under a monopolistic rather than a competitive system. Patient care is difficult to compare, and in any case the consumer does not have the opportunity of expressing a choice. Indeed there is frequently less opportunity for choice in hospital care than there is in many government services.

Hospitals, like governments, are not subject to the same criteria of efficiency that we assume exists in business. To the extent that free enterprise and true competition exist in the business world, sub-par performance usually carries with it a very powerful corrective — the survival of the fittest and the extinction of the less efficient. The rigours of competition and survival do not exist to the same degree for the purveyors of either hospital or government services, and hence there is a real need for some form of periodic review to ensure that these essential activities are so organized that they are able to operate at maximum efficiency.

Most hospital administrators are trying very hard to do the best possible job with the resources on hand, but it is difficult for them or their boards to know at what level of effectiveness they are operating. The arbitrary standards which have been established by some regulatory agencies are at best imprecise yardsticks and leave much to be desired. Because of the absence of reliable standards and the difficulty of developing them, the American Hospital Association began another approach to the assessment of hospital operations in 1959. Instead of attempting to apply statistical standards, Richard Johnson of the A.H.A. developed an indirect approach which was based on the premise that an efficient operation is most likely to be attained in a soundly organized activity — that good organization is the key to good operation. To test this hypothesis he began looking at how hospitals were set up to do their job, and out of this developed a set of organizational criteria. These were applied widely in the U.S.A., and the A.H.A. has made this approach the basis of its hospital counseling program which is provided to hospital administrators on request.

From the work of the A.H.A. we at the Ontario Hospital Association began late in 1960 to offer a similar service to the administrators of our member hospitals. We have called this the Administrative Audit Service and it is available only on request by administrators. Its purpose is to assist the administrator in the review of his organization and operation, starting at the top with the board of directors and including the medical staff, hospital departments and all auxiliary groups associated with the hospital.

The audit consists of a review of formal documents such as the hospital and medical staff by-laws, minute books, et cetera, together with a series of about 30 private interviews conducted in the hospital by the members of the audit team. Prior to the survey the admini-

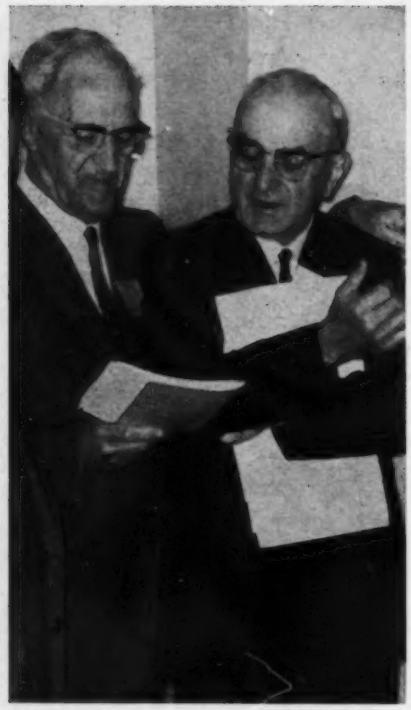
(continued on page 64)

From an address given at the Western Canada Institute, Saskatoon, Sask., 1961.

The author is administrative assistant at the Ontario Hospital Association, Toronto, Ont.

your HOSPITAL —

- registered nurses
- hospital auxiliaries
- practical nurses
- laboratory technologists
- radiological technicians
- social workers
- executive housekeepers
- laundry managers
- c.s.r. supervisors
- public health personnel



Seen above are Judge Milton George and John Gardner, both of whom were accorded life membership in the association.

The smaller hospitals were well represented at the meeting as seen from the group above. From left to right: Helen Moore, matron, Deloraine; Mrs. J. F. Fletcher, superintendent, Benito; Robert G. Keast, secretary-treasurer, Roblin; Mrs. R. C. Steeves, matron, Melita; Mrs. E. Simms, matron, Roblin; and Mrs. L. Martin, Killarney.

WINNIPEG laid on beautiful summer weather for the 10th annual Manitoba Hospital and Nursing Conference which was held at the Royal Alexandra Hotel, October 3, 4, and 5. Besides the Associated Hospitals of Manitoba, some 15 allied organizations held their own meetings in the hotel during the three-day period and also attended general sessions of the hospital association. Arrangements were under a Joint Planning Committee, with P. E. Swerhone of Winnipeg General Hospital as chairman and H. A. Crewson of the Associated Hospitals of Manitoba as general secretary and exhibit manager. The 41 displays of hospital supplies and equipment attracted much attention during the half-hour breaks each morning and afternoon. Total registration at this large conjoint conference was over 1,400.

The general theme for the program was "Your Hospital — Your Community" but the key speaker at the opening session, Andrew Pattullo of the Kellogg Foundation, did a switch on this and in his title put the community first. "We in the hospital world," he said, "must realize that the hospital is but one segment of society" and added that any "holier-than-thou" attitude could but lead to difficult times. Mr. Pattullo saw the public, as well as hospitals themselves, as somewhat confused between the earlier idea of a hospital as a charitable organization and the growing concept of the hospital as a public utility. Each hospital, he said, is now a community enterprise; and responsibility for the quality of care given to patients rests squarely upon boards of governors and their medical staffs. The degree to which these people accept this basic responsibility "will have a tremendous impact upon the control of the hospital system itself in the future."

For small hospitals he urged pooling of resources and sharing of services in a system of integration with larger units. Mr. Pattullo pointed out that Manitoba has shown leadership in this direction through its report accounting system and more recently through the creation of a consultation services program. The Kellogg Foundation is assisting financially in both of these programs. The extent to

your COMMUNITY

- physiotherapists
- pharmacists
- medical record librarians
- dietitians
- purchasing agents

Jessie Fraser

Seen examining various exhibits are three sisters from the Misericordia General Hospital, Winnipeg—Sr. M. Therese, Sr. St. Charles and Sr. St. Veronica.

Discussing some serious matter are from left to right: L. L. Wilson, Canadian Hospital Association, Toronto, Gilbert G. Todd, A. Forkheim and L. A. Fuller, all from Winnipeg.

which hospital people move toward an effective and co-ordinated system of hospital care can mean a new image to the community, stressed the speaker.

Earlier, delegates to the conference were welcomed by the president of the Associated Hospitals of Manitoba, W. T. Andrew of Hamiota; by James Cowan, M.L.A., for the province; Mayor Stephen Juba of Winnipeg; Judge Nelles Buchanan, Edmonton, president of the Canadian Hospital Association; and Peter E. Swerhone, chairman of the general conference.

Regionalization

The concept of integrated hospital services was developed at length by Philip Rickard, administrator, General Hospital of Port Arthur. It will be remembered that Mr. Rickard's early experience was in England where the regional hospital system prevails and that it was he who headed up the first regional hospital council in Saskatchewan. He pointed out that integration of services within regions is not a new idea but has evolved in many older countries "as part of the adjustment needed to balance the impact of scientific and technological advance." The basic idea behind the various schemes is, he said, that there be a flow of professional personnel from the large hospital to the small, and yet a flow of patients from the lower level to the higher level for specialized treatment. "I do not think," said the speaker, "that we can afford to be so parochial as to think only in terms of the acutely sick patient . . . the hospital community should embrace not only the acutely sick but chronic patients, the mentally ill, tuberculosis cases and the aged and infirm." In Mr. Rickard's opinion, building independent geriatric centres and long-term hospitals involves wasteful duplication of service and may well lead to the provision of second-class patient care.

T. A. J. Cunnings, executive director of the Sanatorium Board of Manitoba, who chaired this session, referred to the regional councils being developed in that province and noted the establishment of the Manitoba Medical Centre Council. The Medical Centre is that group of hospitals which have grown up adjacent to the medical college in Winnipeg, according to a design worked out in the forties. These include the Winnipeg General, of course, with its maternity and psychiatric units; the Children's Hospital; the Rehabilitation Hospital which is under construction; and the Manitoba Cancer Centre on which construction has begun. There is already sharing of some basic services among these, such as heat and power, and many other joint services are being considered.

Mr. Cunnings took exception to Mr. Rickard's implication that not enough treatment is provided in large long-term hospitals. He reported that at Assiniboine Hospital in Brandon and at the Municipal Hospitals in Winnipeg many patients are "salvaged" after too long a period in general hospitals—where the emphasis is on the care of the acutely ill. He did agree that long-term hospitals should be close to general hospitals for, among other reasons, the convenience of physicians.

At a meeting of physiotherapists that day, Dr. J. A. MacDonell of Deer Lodge Hospital in Winnipeg, discussed the care of geriatric patients. He was strongly of the opinion that older people should not be kept in general hospitals a moment longer than is necessary because there, too often, rehabilitation is not begun. Staff at the long-term hospital then face the problem of achieving medical stabilization and physical re-education of the aged person. Functional restitution requires much patience and the combined efforts of nurses and physiotherapists under the direction of physiatrists. He described several so-called "hopeless" cases where the persons concerned had learned to walk again under specialized treatment in long-term hospitals.

Joint Action on Nursing Problems

Manitoba has a Joint Committee on Nursing which is comprised of members of the Manitoba Association of Registered Nurses and representatives of the Associated Hospitals of Manitoba. During this 10th annual conference, the Joint Committee held a demonstration meeting on stage in which they reviewed subjects of current interest. The panel of ten under the chairmanship of G. B. Rosenfeld, Victoria Hospital, Winnipeg, brought out the fact that membership in the M.A.R.N. has doubled in the past ten years and the greatest increase has been in the past three years. For the first time in many years, hospitals in Manitoba can be selective in engaging nurses but more are still needed, especially in rural areas. Many small hospitals are partially staffed by married nurses who live on farms. These work from after-harvest-time until sowing begins in the spring, thus leaving the hospital short staffed in the summer months.

It was brought out, too, that the M.A.R.N. has recently set up a committee on recruiting. A letter is being sent to all schools to ask for co-operation in recruitment and it is planned to hold "career days." Also, the Associated Hospitals of Manitoba is producing a careers booklet which will be distributed in the schools.

Because the cost of living is high, a question was raised as to any source of financial assistance for students in training. The meeting was told that the provincial department of education does provide vocational training loans up to a maximum of $400 but even this is not enough if the student has no other source of funds. An effort will be made by the M.A.R.N. to have such loans increased.

The shortage of nursing supervisors came up for discussion and panel members agreed that staff nurses should be encouraged to take the new course in nursing unit administration which is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. A speaker from the floor pointed out that the effort expended by a staff member in undertaking such a course should be recognized in the salary schedule. Nurse administrators in Manitoba have benefitted in recent years through institutes provided regularly by the University, and a number of them have taken the Hospital Organization and Management course.

Three members of the executive staff of the association: W. T. Andrew, immediate past president; C. Grierson, director of counselling service; and H. A. Crewson, executive secretary-treasurer.

The Joint Committee thus shown in action meets regularly throughout the year for an exchange of ideas and information as between the two associations.

Standards in the Spotlight

At a program entitled, "Hospital Standards and Their Effect Upon Operations," Dr. J. Gilbert Turner of the Royal Victoria Hospital in Montreal led off with a challenging address on the topic, "What Are Standards?" A standard, he said, is a degree of excellence required for a particular purpose, and obviously the one all-embracing standard for hospital care is that it be the best possible within the limits of our resources. He traced the development of standards as set out now by the Canadian Council on Hospital Accreditation and pointed out sharply that as of last May only 328 hospitals in Canada had been accredited out of a total of over 800 which were eligible. "How can we possibly say that we are giving the best in hospital care

Seen in the picture is the new executive committee. Back row left to right: P. E. Swerhone, Winnipeg, director; W. T. Andrew, Hamiota, immediate past president; E. Dubinski, Winnipeg, director; E. W. Hawkins, Dauphin, director; and H. A. Crewson, Winnipeg, executive secretary.

Front row left to right: H. Posyniak, Winnipeg, director; G. B. Rosenfeld, Winnipeg, president; Dr. P. L'Heureux, St. Boniface, second vice-president; Marjorie G. Dunn, Hamiota; W. W. Devine, Portage la Prairie, director; and R. J. Hood, Carberry, first vice-president.

Missing from the picture are the following: F. Foster, Brandon, honorary secretary-treasurer; Dr. J. Zmetana, Rivers, director; Major S. Mundy, Winnipeg, director; and J. McIntyre, Winnipeg, director.

The provincial Minister of Health, George Johnson, was named honorary president.

Comparing notes are from left to right: J. E. Riddel, Marjorie G. Dunn, W. T. Andrew, both of Hamiota, and P. N. Goro.

Chatting together after a session are from left to right: J. E. Robbie, Winnipeg; Miss A. C. Deacon, Melita; Mrs. R. Campbell, Killarney; Miss S. Stirling, Grandview; and Miss R. Ogletree, Gilbert Plains.

when more than 50 per cent of our hospitals, for some reason or other, have not been accredited?" asked Dr. Turner. The program can be stimulated and guided by the Canadian Council, he said, but the real work must be done at the local level. "The task rests squarely on the shoulders of the governing board, it's deputy — the administrator — and the medical staff."

Dr. Turner urged that the following message be spread to every hospital in the country: "On the agenda of your next meeting inscribe the item — *Is our hospital accredited?*"

Murray W. Ross, executive director of the Associated Hospitals of Alberta, Edmonton, then discussed "The Application of Standards." He, too, stressed that the prime responsibility for applying standards lies with the governing boards of hospitals from whence it is delegated to responsible staff members, particularly the medical staff who practise in the hospital. But, he said, each profession involved, each person, is a partner in the team. Each is the servant of the patient. But in recent years, Mr. Ross pointed out, the hospital board has acquired a new partner and a powerful one in the form of senior governments. Because of its participation in financing hospital care, each government is taking an increased interest in what goes on in hospitals, including s t a n d a r d s. Moreover, governments are in a position to exert their will through economic pressure, legislation or regulation. More cheerfully the speaker observed: "If we can demonstrate a charity in our purpose, a genuine interest in producing the best results from the standpoint of the patient, and the judgment and competence required to do a good job, then our voice will be heard."

Mr. Ross urged increased emphasis on educational programs. Only through well-trained people can standards be applied. There is an intensified need, too, for well-developed systems of consulting services operated by the hospitals through their associations. Finally, the speaker suggested that "under the broad requirements of legislation, and consistent with the . . . requirements of regulations, the hospital by-laws become the keystone for the application of standards in individual hospitals." He urged that hospitals must do a better job of marshalling their resources and of pooling the knowledge and experience which their staffs, lay and medical, possess.

The guest speakers then joined a panel for discussion of the general topic. On the panel were a trustee, V. E. Fulton of Birtle, Man., a physician, Dr. R. O. Flett, Winnipeg, and an administrator, A. K. McTaggart, Brandon.

Much concern was expressed about the application of standards to small hospitals of 25 beds or fewer, which are not now covered by the accreditation program. The consensus was well summed up by Mr. McTaggart when he said: "Manitoba hospitals consider that the standards of the Canadian Council on Accreditation . . . can be economically and effectively applied to all hospitals in this province by *extension* of that program through a provincial council made up of representatives of government, the medical profession and hospitals, utilizing the best of our available manpower in the continued public interest."

How the Community Sees the Hospital

With Judge Nelles V. Buchanan, president of the Canadian Hospital Association as moderator, a panel of five citizens set forth their opinions about and reactions to hospital. These included R. Usick of the Manitoba Farmers' Union, Dr. K. I. Johnson, an industrial physician from Pine Falls, Mrs. J. K. Edmonds, an economist, Mrs. D. V. Pennock, a housewife, and E. W. Hawkins, Q.C., chairman of the board, Dauphin General Hospital. One opinion common to all speakers is that hospitals do not give out enough information to the public, and the public has thus no way of evaluating hospital service. Another speaker deplored the fact that all specialties are centered in Winnipeg. There was a request for regionalization and larger hospitals at the core of each region.

G. B. Rosenfeld of Victoria General Hospital, Winnipeg, discussed the various means of getting the hospital's story across to the public and convincing them that each person still has a responsibility toward his community hospital. Hospitals must, it was made clear, take the initiative in counteracting an impression, unfortunately too widespread, that the government now owns the hospitals. It was urged by several speakers that this is one sphere where the women's auxiliaries can do invaluable work. And the information was volunteer-

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Psychological Problems in General Hospitals

Jean Dorgan, B.app.Sc., M.S.W.
Ottawa

THE general hospital is regarded by the majority as a place of healing, an institution devoted to the study, the treatment and, hopefully, the cure of people who are suffering from disease. But the hospital is also an organization of people, in which doctors, nurses, technicians, administrative and maintenance personnel must work within a large plant in various relationships with each other and with the ultimate objective of providing a medical service to the patients. In other words, it has most of the psychological and emotional problems of human relations that any large industrial corporation has, with the important added complication that the purpose of the institution is to provide a service to a collection of human beings who themselves have tensions, sensitivities, emotional needs and so on.

Studies of these psychological and emotional problems as they exist in industry have frequently been made and have led to increased interest and skill in the management and training of personnel and improved efficiency in production. For some time the World Federation for Mental Health* has been planning a study of psychological factors in general hospitals to be made simultaneously in several countries. It was felt that a very informal procedure might be followed, where interested members of the staff, representing several professional disciplines, as well as perhaps the patients themselves might meet regularly for discussions about the psychological problems which they have recognized in the hospital. The co-operation of two other international bodies, the International Council of Nurses and the International Hospital Federation was secured and the study proceeded under their joint auspices. Responsibility for organizing study groups in Canada was delegated to the Canadian Mental Health Association, the Canadian Nurses' Association and the Canadian Hospital Association, representatives of which formed the Steering Committee which was responsible for launching the Ottawa Study Group in April 1959.

The Ottawa Study Group was composed of representatives from three general hospitals and one hospital for the chronically ill in Ottawa; a director of a university school of nursing; a representative from the Canadian Nurses' Association; a representative from the Mental Health Division of the Department of National Health and Welfare and a psychiatrist in private practice. The following disciplines were represented: psychiatry, nursing, social work and professional non-medical hospital administration.

When the Ottawa Group began its work it felt that there were situations inherent in the experience of hospitalization which probably created or aggravated emotional problems, and a small survey on the wards of the participating hospitals was conducted by student nurses. Although the results were not conclusive, it did indicate that at least part of the difficulty had to do with the process of communication. Specific reference was made to ineffective communications between staff and patients; lack of communication among staff; and problems in communication prevailing right up the line of authority. Communications therefore became the focus of the study.

One particular aspect in connection with hospitalization — the admitting procedure — revealed that there were many things that could be changed even in this one aspect of hospital work, provided there were effective means of interdepartmental communication.

The Ottawa Study Group held nine meetings the first of which took place on April 7, 1959. Its findings were contained in a report which was forwarded to the London headquarters of the World Federation for Mental Health in May 1960.

Following the submission of reports, the World Federation for Mental Health requested each group to send a representative to a meeting in London for further discussion. The recorder of the Ottawa Group was nominated to attend.

The meeting took place in London, October 25 to 28 inclusive. For four days representatives from study groups in the United Kingdom, United States, France, Canada, Switzerland, Scotland, Italy, Finland, Spain, and West Berlin discussed the development of their groups, approaches to the study, problems and achievements, under

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The author is consultant in social work to the Mental Health Division, Department of National Health and Welfare, Ottawa. She acted as recorder for the Ottawa Study Group.

** An international non-governmental organization involving more than 60 countries and dedicated to the improvement of treatment of the mentally ill throughout the world and the protection and improvement of mental health.*

the chairmanship of Dr. Kenneth Soddy, scientific director, World Federation for Mental Health, assisted by Elizabeth Barnes, co-ordinator of study groups.

The following professions were represented: medicine (three psychiatrists, one intern and one paediatrician), two psychologists, two nurses and two social workers, exclusive of Dr. Soddy and Miss Barnes. Discussion was in English and French with simultaneous translation provided.

News and ideas travel fast in the jet age. Nevertheless the consistency with which the same problems appeared in the study group reports was quite astounding. For example, prior to the London meeting, the Ottawa Study Group secured a vivid and spontaneous account of one person's experience in being admitted to hospital. The account was not hostile but it did illustrate an undesirable impersonal "assembly line" technique. With minor changes to disguise its origin it was forwarded to all study groups, and without exception each group thought it came from its own country!

Discussion was organized under four main headings: organization of the study; patients' problems; hospitals' problems; and future action.

Organization of the Study

The following observations were contributed by the co-ordinator of study groups.

1. Hospital studies did best when undertaken by those who thought it would help them in their work.

2. There were two main approaches — research and discussion. Discussion was difficult to evaluate as minutes did not mirror the change in attitudes which take place following discussion. The Rome group used the research method because it was felt to be the only way to involve individuals in a position to effect change.

3. Some groups failed to get started because hospital administration did not understand the purpose of the study and feared it would "stir up trouble."

4. Groups composed of individuals from different settings usually were more objective than those whose members all came from one hospital and were, therefore, prone to particularize. (The Ottawa Study Group was of the former type.)

Patients' Problems

The value of questionnaires as a means of discovering patients' feelings elicited considerable discussion. It was felt by some that few patients will risk negative comments in a situation which they cannot control. On the other hand some patients were quite impressed to learn that their opinions were considered useful and this had a positive effect. The old familiar complaints about early waking, cold meals, and so on appeared more often than feelings related to dependency, lack of privacy and lack of interest in the patient as an individual. Apparently most patients need to develop a secure relationship with at least one important individual in the hospital before they feel free to say what they *really* think. The representative from Rome noted that questionnaires often yield dividends. One patient had the courage to complain that the bell in the clock tower, marking the quarter hours, made it impossible to obtain a night's rest. It was promptly silenced; no mean achievement since the hospital was a 15th century establishment and the bell had been ringing for more than 400 years!

Discussion of admitting procedures stressed the need for privacy, respect and sensitivity on the part of the admitting personnel and the importance of *one* individual being responsible for patients until they are conducted to the ward where the head nurse takes over. It was felt that admitting personnel very often have no understanding of interpersonal dynamics and that training in this aspect of their work should be provided.

It was felt also that patients and their families often experience unnecessary difficulty in securing information from hospitals. A suggested solution was to make one specific doctor responsible for interpretation. This procedure should prevent undue worry on the part of the patient and avoid relatives getting "the run-around."

Ward rounds were considered particularly hazardous in creating anxiety and the practice of having an assistant doctor follow the chief's ward rounds, to answer patients' questions immediately, was advocated.

Children in hospital are receiving increasing attention. The United Kingdom seems to lead in permitting unlimited visiting from parents. By this means the child who is too young to understand that the separation from parents is temporary can, to a great extent, be protected from damage. Spain favours prevention and every effort is made to treat children in their own homes until after the second birthday at least.

The physicians in the group felt that few if any childhood illnesses require that visitors remain behind glass walls or that they wear gowns and masks. The frustrations for the child plus the fact that visitors, through lack of understanding, usually defeat the purpose of such precautions were considered to offset any possible value they might have.

Hospital Problems

No strong position was taken on "rooming-in". It was felt that some mothers would prefer to be alone in order to obtain much needed rest and that this is a matter for individual decision.

With reference to hospital visiting generally it seems that many hospitals now permit unlimited visiting during the day; this has the effect of distributing the strain for both patients and visitors and is preferred to the old method. It did, however, create some strains in a Scottish hospital where, when restrictions were removed, relatives felt it was their "duty" to remain all day!

It was surprising, for a Canadian, to learn that exclusion of children, under 16, from hospital visiting is apparently less rigidly enforced in other countries.

Concomitant with relaxation of rigid rules about hospital visiting hours was the feeling that head nurses should take more responsibility for controlling visitors since patients find this hard to do.

The necessity for respecting the patients' individual needs, while in no way weakening the therapeutic function (which is after all the primary responsibility of the hospital), was the core of discussion on this aspect of the study.

Concern was expressed that, because of the increasing complexity of modern hospital techniques, much of the actual care of patients is delegated to staff members with the least training. It was felt that communication with this group could be improved. Some of the doctors, as usual, regretted the passing of "the good bedside nurse" but they were reminded that the modern patient spends very little time in bed and that nurses are increasingly involved in highly technical procedures which leave them little time for the more personal aspects of patient care.

Considerable attention was devoted to the "dehumanizing" pro-

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43rd annual convention

SASKATCHEWAN HOSPITAL ASSOCIATION

BECAUSE Saskatoon played host to the Western Canada Institute for Hospital Administrators and Trustees in June of this year, the 43rd annual convention of the Saskatchewan Hospital Association was limited to a two-day business meeting. This was held at the Hotel Saskatchewan, Regina, on October 5 and 6.

Delegates were welcomed by the president, Dr. A. L. Swanson of Saskatoon, by His Worship, H. H. P. Baker, Mayor of Regina, the Hon. J. Walter Erb, Minister of Health and honorary president of the association, and greetings from the national office were brought by C. E. Barton of Regina who is second vice-president of the Canadian Hospital Association.

A guest speaker was Dr. A. C. Hardman, chief, Emergency Health Services, Ottawa. His topic was "Disaster Planning for Hospitals" and he urged that each and every hospital set up a specific program which could be put into operation at very short notice. His talk was illustrated by slides.

Mrs. L. Korman reported on the activities of the Saskatchewan Hospital Auxiliaries Association; Mrs. Margaret Frejd for the Medical Record Librarians Association; and Gordon Brown spoke for the Saskatchewan Branch, Canadian Association of Hospital Pharmacists.

Officers for 1961-62

The officers of the Saskatchewan Hospital Association, elected at this meeting, are as follows: immediate past president, Dr. A. L. Swanson, Saskatoon; president, Don A. MacMillan, Yorkton; and vice-president, Rev. Sister Margaret Marie, Prince Albert.

Representatives of hospitals under 25 beds, Royce Gill, Leader, and O. D. Jacobs, Kyle.

Representatives of hospitals 25 to 99 beds, Dr. H. S. Jamieson, Moosomin, D. Z. Daniels, Canora, and A. W. Holtby, Melfort.

Representatives of hospitals over 100 beds, George Bolen, Moose Jaw, C. E. Barton, Regina, Harry Richardson, Saskatoon, and L. T. Muirhead, Saskatoon.

Seen above are the executive directors of the Saskatchewan Hospital Association for 1961-1962. Back row left to right: H. Richardson, Saskatoon; R. Gill, Leader; L. T. Muirhead, Saskatoon; G. Bolen, Moose Jaw; O. D. Jacobs, Kyle; and A. W. Holtby, Melfort.

Front row left to right: J. D. McMillan, Regina; D. Z. Daniels, Canora; Rev. Sister Margaret Marie, Prince Albert; Don A. MacMillan, Yorkton; Dr. A. L. Swanson, Saskatoon; C. E. Barton, Regina; A. R. Thorfinnson, Regina; and Dr. H. S. Jamieson, Moosomin (missing from the picture).

A highlight of the annual banquet was the address given by M. F. Kushnir, the recipient of the Smith-Walshaw Memorial Award. (See page 14.)

In Mr. Kushnir's speech, he deplored the shortage of well trained personnel especially in the smaller hospitals, and called on the associations at the national, provincial and regional levels to remedy this problem. Mr. Kushnir suggested that the number of institutes and training programs provided by the associations should be increased, especially for the department heads. But care must be taken that there is no duplication of any program in any area.

Another duty of the provincial association, according to Mr. Kushnir, is to keep member hospitals informed at all times on hospital trends and changes. The hospital administrator must have an outside contact and source of information. Mr. Kushnir also emphasized the importance of hospitals acting collectively to make their voice heard and their influence felt. It is important that every hospital in the province be a member of the provincial association and help to strengthen it as much as possible. "We should do more for ourselves and not ask for assistance at every turn of the way from the government and others," claimed Mr. Kushnir.

Resolutions

AMONG the resolutions adopted by the Saskatchewan Hospital Association at its annual meeting were the following:

● BE IT RESOLVED that where major repairs are not allowed as an operating expense, but are considered as being of a capital nature by the Hospital Rate Board, these

(concluded on page 80)

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PR—
a contemporary approach

Henry J. Schankula
Toronto, Ont.

PUBLIC relations is part and parcel of the hospital institution; as much a part of it as the building materials of which the hospital is constructed. The hospital in modern society needs good public relations because it needs friends. It is a public service institution and, as such, it is under constant and critical scrutiny by the community—by the patient, his family, and his friends; and by its own staff and employees. In addition, the reaction of a visitor to the hospital may carry as much weight in the community as the reaction of a patient.

This continual scrutiny of the operations of a hospital necessitates a program of education, which is one of the basic beams in the structure of public relations. The hospital connot give adequate service without public acceptance and support and this can only be achieved through public understanding of the hospital's hopes, aims, and problems.

For the patient, public relations means realizing that the services are adequate in quality, pleasant, efficient, and effective, and certainly, having the assurance that the cost of service is kept as low as possible. For the community, public relations attempts to bring understanding of current hospital programs and activities, problems and progress, and the assurance that the hospital's services will always be available when required. It has often been said that "your best public relations is good patient care." The community respects the hospital and understands its problems and the contribution it makes to community life by the quality of care given to the patient. In hospitals, as well as in business, the best advertisement is a satisfied customer.

The author is administrative assistant at Toronto General Hospital, Toronto, Ont.

The principal method of gathering contemporary data concerning hospital public relations problems, techniques and methods, is by distributing narrative-type questionnaires to selected hospitals in Canada and the United States. The information gathered through a survey of 96 sources was supplemented by interviews with administrative hospital personnel and by personal observation.

Survey Results

- Slightly in excess of 40 per cent of the hospitals indicated that one of their major problems in the area of public relations was the explanation of high hospital costs and justification of rates for certain procedures.

- The regulations of visiting hours, visitor control, and explanation of services offered by the hospital were the next greatest areas of public relations concern by hospital administrators.

- Other problems encountered by hospitals represented situations due only to the geographical or physical location of the hospital or personalities involved.

- All the current modern methods of communication are being employed in various degrees by most hospitals. Newspaper and periodical publicity has been in the past, and still is, the most effective means of transmitting organized and formally prepared information to the public. Radio, television, and occasionally motion pictures, supplement the printed word as a tool of communication.

- Some hospitals and hospital associations have, in the past few years, developed press codes and close harmonious working relationships with the mass media communication industries in their community. There is, however, still room for improvement in the press codes and relationships between hospitals, their various associations, and the newspaper, radio and television industries.

- 60 per cent of the hospitals indicated specifically that their publication for patients was one of the major techniques in improving the public relations problem area experienced in their particular hospital. By explaining the many ways the hospital is geared to accommodate the patient in his time of need, this special literature serves a valuable purpose in giving the patient confidence when he needs it most.

- Slightly less than 30 per cent of the hospitals provided written material for visitors and relatives for better understanding of the hospital's operation, rules and regulations, and various other items of information that would be of interest.

- In the past few years, hospitals have placed greater emphasis on the rôle of the employee in the public relations situation. No doubt, the expansion of the personnel administrative function in the hospital has resulted in more conscious aspects of employee relationships being developed in the field of public relations. Booklets for patients, house organs and the like, are evident in most of the well organized public relations departments.

Changing Hospital Rôle

The rôle of the modern hospital in the community is constantly changing. Rapid advancements in the field of public relations have been made in hospitals during the past few years, but most authorities still consider this area in a state of transition and change. With the advent of more advanced and comprehensive types of medical and health insurance, and the greater emphasis on public education in the fields of health and medical care, the rôle of the hospital has become more important. The public has become more sophisticated in its outlook and the hospital, in order to satisfy consumer demand, has had to improve its services and relate its problems and community benefits in a more business-like and professional manner.

Most hospitals today have awakened to the obvious fact that they must take the initiative and present their case in order to create widespread interest, understanding, acceptance, and ultimately, support. ■

International Co-operation in Dietetics

Jean C. Macdiarmid,
B.H.S., R.P.Dt.,
Ottawa

CHURCH House, Westminster, London, England, in the shadow of Big Ben and Westminster Abbey, was the scene of a great gathering of dietitians from all parts of the world during the second week of July, 1961.

The Third International Congress of Dietetics brought together 839 dietitians from 40 countries.[1] Forty-nine other dietitians had demonstrated interest by registering in advance, but for unavoidable reasons, were unable to be present.

A formidable five-day session was opened officially by Lord Boyd Orr, honorary president of the Third International Congress of Dietetics. The Right Worshipful the Mayor of the City of Westminster and the Parliamentary Secretary of the Minister of Health in Her Majesty's Government extended greetings to the Congress body.

The theme of the Congress, "Tradition, Science and Practice in Dietetics," was chosen wisely by the interim committee which had met two years ago in London, to outline the program. This was a meeting of dietitians whose professional concern is the practical application of the theories of nutrition to the problem of feeding human beings in health and in sickness.

The Congress body could be likened to a miniature United Nations. Dietitians from 40 of the approximately 200 countries in the world were gathered together because of their mutual interest in the betterment of the nutritional status of their people.

The tone of the Congress was established by the first speaker, Norman C. Wright, Food and Agriculture Organization of the United Nations, with headquarters in Rome, Italy. F.A.O. itself has, as one of its objectives, the first point in its three-fold objective brought forth at Quebec in 1945—to raise levels of nutrition and standards of living. In co-operation with the World Health Organization, the degree of malnutrition, as distinct from undernutrition, existing throughout the world has been determined. Attention has ben drawn forcibly to the magnitude of the problem of protein malnutrition. Emphasis has been laid on assistance to countries whose food supplies are inadequate, and on optimum utilization of available food supplies, especially available protein sources. The need has been established for international collaboration in the solution of problems concerned with human diet. Mr. Wright declared that it was the responsibility of those in attendance at the Congress to ensure that the progress so far achieved in international collaboration is not merely maintained, but is increasingly directed towards alleviation of human misery and the achievement of human dignity.

The Third International Congress of Dietetics was in itself an indication that there were no international barriers in the advancement of scientific knowledge of nutrition and its application.

We are apt to think in terms of Canada's Food Guide as the basis of sound or adequate nutrition. It was interesting to hear about the food patterns of other countries; patterns influenced by availability of food supplies, climate, topography of land, living conditions and religious beliefs.

There was valuable discussion of the education and occupations of dietitians. The educational background of dietitians varies from country to country. Some countries (Canada included) offer courses of four years' duration at university level leading to a degree. Some countries offer courses of two years' duration. There is a diversity of training.

At the same time, the term "dietitian" varies from country to country. Miss Jean Ritchie of F.A.O., Rome, Italy, explained that in some countries the term "dietitian" applies to professional workers responsible for feeding large groups of people, and for diet therapy. In other countries, the term applies to workers in many aspects of the nutritional field. Miss Ritchie ably defined the term when she said, "The dietitian is a practitioner of applied nutrition, interpreting the findings of research in biochemistry, physiology, food technology, sociology and a number of other sciences in terms of food and feeding."

At the present time, the training for dietitians in Germany is not at university or equivalent level. In a few years, Germany is going to have another type of dietitian or specialist in nutrition and dietetics. It will be a new profession with a university career.[2]

We think of dietetics as a young profession in Canada. In truth,

(continued on page 96)

The author is director of the Dietetic Services Division, Department of Veterans Affairs, Ottawa.

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Training Course for Housekeepers

Donald F. Moffatt
Ottawa, Ont.

A MAJOR revolution in hospital operation is occurring to-day. The story of the hospital housekeeping department is well known; the housekeeping function has always struggled at the bottom of the hospital's operating hierarchy and in contrast with most other hospital services, housekeeping has received little recognition or respect. In too many instances, housekeeping has been an unwieldy, disorganized function, subject to much abuse and criticism.

Times have changed and housekeeping has come of age, mainly because of the efforts of progressive housekeepers whose job it was not to lament about the past but to accomplish in the present and build for the future. Housekeeping in some hospitals has become an efficient and economical service entity, managed by a trained housekeeper-administrator and enjoying equal status with other major service departments. In short, housekeeping has become one of the most vital forces in our hospitals today.

The keystone of good hospital housekeeping is the executive housekeeper. Unfortunately, there remains an acute shortage of properly trained and qualified housekeepers, although more and more emphasis is being placed on the employment of such individuals. Low housekeeping performance and low interest return on the housekeeping dollar result in a costly situation. Since labour makes up about 90 per cent of the operational costs of the housekeeping department, we can no longer employ people haphazardly, in the pious hope that somehow the job will be done. Each job must be evaluated and the skills necessary for the job, taught. The economics of the running of the housekeeping department demand that we get eight hours of work per day at the most efficient tempo possible.

To ensure efficient operation in this department, training in modern techniques and concepts of housekeeping management are required. Administrators see now, more than ever before, that good people trained in good systems by good instructors are as necessary in housekeeping as they are in any other hospital department.

Thus, with two main purposes in mind (*i.e.*, the training of potential executive housekeepers and the development of a continuing and co-ordinated in-service training plan for maids, cleaners, wall washers and other housekeeping personnel), the Hamilton General Hospitals, in October 1959, embarked on an ambitious but successful in-service training program for housekeepers. Wednesday, May 31, 1961, marked the graduation of the first eight housekeepers from the course. T. A. Irwin, chairman of the board of governors of the hospitals, presented diplomas to the following: J. Basilio, Mrs. H. Baulcombe, Mrs. J. Bryce, D. Buckthorpe, Mrs. M. Cameron, Mrs. E. Ellison, Mrs. D. Goloviznins and Mrs. L. Melichar. The second class of eight housekeepers-in-training will complete the course in December, 1961.

The course was formulated and conducted by Bramwell Allington, assisted by Arnold Aspin, and they received special honorary diplomas as momentos of the work they did. The supervisors-in-training were carefully recruited, for the most part, from sources outside the hospital. Many had little or no housekeeping background.

The course is a combination of theory and practice and takes 20 months to complete. It is divided into three main segments:

1. *Theory.* This portion requires a minimum of 200 hours of special instruction on the following subjects: (a) hospital organizational chart and other major aspects of housekeeping management; (b) organization, planning and co-ordination of the housekeeping department, including such topics as training methods, time and motion studies, work schedul-

(continued on page 102)

Graduates of the course, back row left to right: Mrs. H. Baulcombe, Mrs. J. Bryce, Mrs. M. Cameron, Mrs. E. Ellison, Mrs. L. Melichar, and Mrs. D. Goloviznins. Front row left to right: D. Buckthorpe and J. Basilin.

The author is administrative assistant at the Ottawa Civic Hospital, Ottawa.

with the auxiliaries

White Cross Guild Reports Busy Year

The White Cross Guild of the Winnipeg General Hospital in Manitoba was engaged in a number of projects during the past year—baby photography, a beauty shop, rag drive, a floral display, buy-a-bargain day, and a travelling shop. At the 15th annual meeting held recently, the out going executive director, Mrs. F. L. Atkins, reviewed the work of the 268 members who donated 25,416 hours last year in the hospital working at the following: pre- and post-natal clinics, admitting, courtesy and flowers, library, shopping service, out-patients' department, ward work, cancer clinic, arthritis, medical records, discharge service at the pavilion, central supply, play therapy, pharmacy, sewing, and assembling the hospital paper and diet manual.

A new service this year is the assembling and mailing of supplies and instructions for patients undergoing treatment at home. A volunteer teaches a course in ceramics, and fires the clay in her own kiln at home.

Mrs. W. E. Barnard will continue as president of the Guild. Mrs. F. K. Atkins, who is resigning as executive director, will be succeeded by Mrs. A. L. Bragg.

International Hospital Project for Canadian Auxiliaries

The National Council of Hospital Auxiliaries of Canada has inaugurated an international hospital project for auxiliaries across the country. Two young Canadian doctors left recently to work in South-East Asia under the auspices of MEDICO (Medical International Co-operation). The hospital where they will be working is in urgent need of all kinds of surgical equipment. The National Council has asked each hospital auxiliary in Canada to make a donation toward supplying this hospital's need. It is hoped that this project will develop wider horizons and a spirit of awareness and concern among auxiliary members for those in other countries who urgently need medical assistance.

B.C. Hospital Has Two Active Auxiliaries

The junior women's auxiliary to Mission Memorial Hospital, Mission City, B.C., recently bought two recovery stretchers and a dressing carriage for the hospital. In an effort to increase membership this year, each member was asked to bring a guest to the first meeting of the fall session.

The senior auxiliary purchased the following items over the past year: one pair of Buck's extensions at $94; bed, chairs and mattresses for a private room at $316; and 28 Christmas gifts for the patients at $23.

Children's Ward Aided by $3,000

The R.C.A.F. Greenwood Chapter of the women's auxiliary to Soldiers' Memorial Hospital, Middleton, N.S., recently presented the hospital with a cheque for $3,000 in final payment of their commitment to the children's ward. This money was raised by a card party, fashion show, calendar sale, opportunity shop and carnival.

Norfolk Auxiliary Has Grown Over the Years

When it was founded in 1925, the women's auxiliary of Norfolk General Hospital, Simcoe, Ont., consisted of a small group of women who met to sew bed linens. Since then, it has grown, amalgamated with another auxiliary group, and has now reached the stage where its activities are many and diverse.

Through the years the group has remained aware of the need for replacement of equipment in the two nurses' residences and in the hospital. During 1960 alone the members contributed $2,248 toward the painting and renovation of some hospital rooms, the purchase of overbed tables and some new furniture for one of the nurses' residences.

Pathology Department Receives New Equipment

A new piece of equipment for the pathology department has been donated to St. Joseph's Hospital in Sudbury, Ont., by the women's auxiliary. The equipment consists of an electrophoretic system which includes an electronic brain and seven other units, valued at $3,000.

Memorial Fund Set up by Auxiliary

The three senior auxiliaries of Welland County General Hospital, Welland, Ont., are currently operating a memorial fund, the proceeds of which will be used to provide life-saving equipment for the hospital. Operated as a joint venture, the fund will be maintained through memorial tributes, and the names of persons for whom the tributes are received will be recorded in a book of remembrance in the hospital.

- At the annual meeting of the St. Joseph's Hospital Women's Auxiliary, Brantford, Ont., it was reported that the group raised a total of $4,159 over the past year. Among the many projects carried out by the members of this group are the setting up of display cases throughout the hospital, programs and gifts for patients and the provision of layettes for needy mothers in hospital.

- The women's auxiliary to Trenton Memorial Hospital, Trenton, Ont., recently presented the hospital with a cheque for $4,000 to help with the building and furnishing of the paediatric ward.

- The Winfield junior hospital auxiliary recently presented Kelowna General Hospital, Kelowna, B.C., with a machine for heart stimulation, valued at $680.

- The women's auxiliary to St. Joseph's Hospital, Saint John, N.B., recently gave the hospital an anaesthetic machine valued at $1,100. Current projects for the members are an operating table at a cost of $2,900 and $25 to help outfit a mobile medical unit for a Canadian doctor travelling in Asia.

For 1962 include

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and

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Administrative Audit

(continued from page 43)

strator completes and returns a lengthy questionnaire, together with a copy of the hospital and medical staff by-laws, organization chart and any other relevant material such as policy and procedure manuals. During a three-to-four-day hospital visit the members of the survey team review the minute books of the board, medical staff and their committees, and meet privately with selected members of these groups and senior employees. A meeting in which the findings and comments of the audit team are reviewed with the administrator completes the visit, and the only written report of the survey is subsequently prepared and forwarded to the administrator. This service provides essentially the same review as the hospital counseling program of the A.H.A. It is a study of organization, and has as its major premise that, with given resources, one is most likely to obtain an effective result through sound organization. Obviously, sound organization does not guarantee efficient operation, but it greatly increases the possibility of such a result.

The process of evaluation entails a comparison between the actual organization of the hospital and a theoretic ideal, and for this purpose a number of criteria were set down by the A.H.A. These are being followed by us with a few minor modifications. Some of the criteria are listed below.

Governing Authority

1. The governing authority is organized in an acceptable manner, and meets regularly as an organized body with a majority of the members attending each meeting.
2. Individual members support the formal actions of the governing authority.
3. It formalizes the terms of employment of the administrator.
4. It delegates all internal operations of the hospital to the administrator and clears all official contacts with hospital personnel through the administrator.
5. It formalizes policy in hospital operation; it enacts policy only after giving the administrator an opportunity to recommend a course of action; and it holds the administrator accountable for operating the hospital in accordance with established policy.
6. It requires predictability in the financial operations of the institution and an impartial financial audit at regularly scheduled intervals.
7. It receives those reports necessary to enable it to properly evaluate the operations of the hospital.
8. It formally approves the organization, by-laws, rules and regulations of all community groups primarily identified with the hospital, and it requires a review and approval of all projects, activities and expenditure of funds raised by such groups.
9. It accepts responsibility for the standard of medical care practised in the institution.

Medical Staff

1. The medical staff is organized in an acceptable manner.
2. Records exist to substantiate the professional qualifications of physicians appointed to the staff.
3. A file of rejected applicants is maintained.
4. Members accept the prerogatives of the governing authority and the administrator.
5. Permanent records of medical staff activities are maintained.
6. The organized medical staff is held accountable by the hospital board for ensuring that the standards of hospital-medical care are met and maintained.

External Relationships

1. The hospital adheres to all laws and regulations pertaining to it.
2. It co-ordinates its activities with other health and welfare agencies of the community, and routinely informs the community of its activities and programs.
3. It maintains formal relationships with appropriate local, provincial and national hospital organizations.

Internal Operations

1. Areas of responsibility within the hospital organization are clearly defined.
2. The authority necessary to carry out assigned responsibilities is delegated.
3. Personnel are held accountable for their assigned areas of responsibility.
4. All persons employed by the hospital are responsible to the administrator or to his designated representative.
5. Personnel policies and practices are formalized and disseminated through the organization, and standards of performance are established.
6. New employees receive instruction in procedures during the initial phase of employment, and their performance is periodically evaluated and recorded. Appropriate and consistent disciplinary action is taken when employees do not conform to established standards of job performance or conduct.
7. Procedures, rules and regulations established in the hospital are consistent with the policies of the governing authority, and are enforced to ensure compliance with such policies.
8. Hospital procedures are formalized, standardized to achieve uniformity in operations, and routinely distributed to all departments and services affected.
9. The program for the maintenance of physical plant and replacement of equipment adequately protects and preserves the hospital assets.
10. The hospital has an organized method of forecasting future operations.
11. Administration is routinely informed of hospital activities and periodically reviews and evaluates patient care.
12. Internal committees formed by administration are used in an advisory capacity.
13. The principle of medical staff self-government is accepted by the administration of the hospital.
14. Administrative and supervisory personnel have adequate experience and necessary education for the positions in which they are employed.

In carrying out an audit, it is obviously necessary to translate these abstract criteria into specific questions. To illustrate this let us look at the first criterion under internal operations — "Areas of responsibility within the hospital internal organization are clearly defined."

In order to determine the degree to which this statement applies in a particular instance, it is necessary to find out what concept board members have of the administrator's job. Is the administrator the chief executive officer of the board? Does he or his delegate hire and fire all hospital employees? Do board members clear all contacts with hospital employees through the administrator? Do any employees report directly to the board without being requested to do so by the administrator? Is there a formal organization chart available and in the hands of all persons interested? Does this chart truly

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reflect the actual organization? Is there a written description for each job within the organization, particularly the senior jobs; and does this specify responsibilities? Within the limits of the jobs defined, is each person held accountable by his superior? Do employees appear to have a good understanding of for what and to whom they are responsible?

This in brief is an outline of the purpose and method of the Administrative Audit Service. We in Ontario are just beginning this service and hence are not justified in generalizing from our experience to date. On the other hand, the A.H.A. has completed over 100 surveys and formed some general observations. Possibly a group such as this could decide how applicable these are in the administration of Canadian hospitals.

In terms of board organization there appeared to be an almost universal problem of maintaining the interest and participation of competent citizens to serve as hospital trustees. Because of this difficulty there was sometimes little or no turn-over in membership and hence no new blood coming along to provide for future leadership in hospital matters. There appeared also to be a fairly common problem of overlapping of functions by committees, and some tendency for committees to act other than in an advisory capacity to the board. As would be expected, such lack of organization served to discourage trustees, and it was suggested that clearer definition of committee functions and responsibilities would be helpful. It was found that a number of governing boards had a very limited vision of their rôle: they did not take much interest in or accept much responsibility for the quality of hospital-medical care. Undoubtedly because of long years of financial difficulties, they had come to see the purpose of the board as being purely one of financing.

In terms of the administrator, the A.H.A. staff believed that the authority and responsibility of the administrator as chief executive officer should be better defined and understood. They observed a tendency for administrators to be preoccupied with internal hospital operations at the expense of their vital rôle as co-ordinators between the governing authority, community, medical staff and hospital. Many administrators tended to regard their rôle as primarily a fire-fighting one, of meeting and solving day-to-day problems — a rôle which by its nature tended to be self-defeating. It was thought that they could benefit from greater use of the formal tools of management. The tendency to rely on personal contact and verbal instruction was not always adequate as hospitals expanded, and the lack of delegation and effective controls resulted in slowness in decision-making, lack of information, duplication of effort, repetitive decisions and interdepartmental friction. Some administrators seemed unable or unwilling to match delegated responsibility with commensurate authority, possibly because of difficulty in defining the jobs they wanted done and in developing adequate measures to ensure accountability for delegated responsibility.

We have been delighted by the enthusiastic response of administrators to the audit service, and even though we have had limited experience so far, we are prepared to say that it is very worth-while. We have much to learn from this work but we are confident that the knowledge to be gained will be of value not only to the participating hospitals but to the whole hospital field.

The author gratefully acknowledges the major contribution of the American Hospital Association and its staff who have been more than generous in sharing their knowledge and experience in this work. ■

Ontario Extends Aid for Mental Patients

Mental patients in Ontario are to be helped from the moment they begin treatment to prepare for the time when they return to their families and seek new jobs. At the 12th annual meeting of the Ontario Public Health Association, the Hon. Matthew Dymond, Ontario Minister of Health and Welfare, described Operation New Start — the name given to expanded rehabilitation services connected with Ontario hospitals and out-patient clinics. Planned by the Health Department's rehabilitation branch which was set up in September, 1960, the program has been operating experimentally on a restricted scale since last April. Already 450 patients have been rehabilitated.

The expanded program will involve training for patients without the skills to get a suitable job; more education for those needing and wanting it; persuading employers to accept former mental patients; and approaching the patients' families in an effort to help them understand the patients' problems when they return home.

New Training College for Salvation Army

Construction of a new $1½ million national training college for the Salvation Army has begun in Toronto, Ont. Upon completion, the new college will house 120 cadets. The 85,000 square-foot, four-building cluster will include classrooms, a chapel, an administration block, and men's, women's and married quarters. The architects are Marani, Morris and Allan.

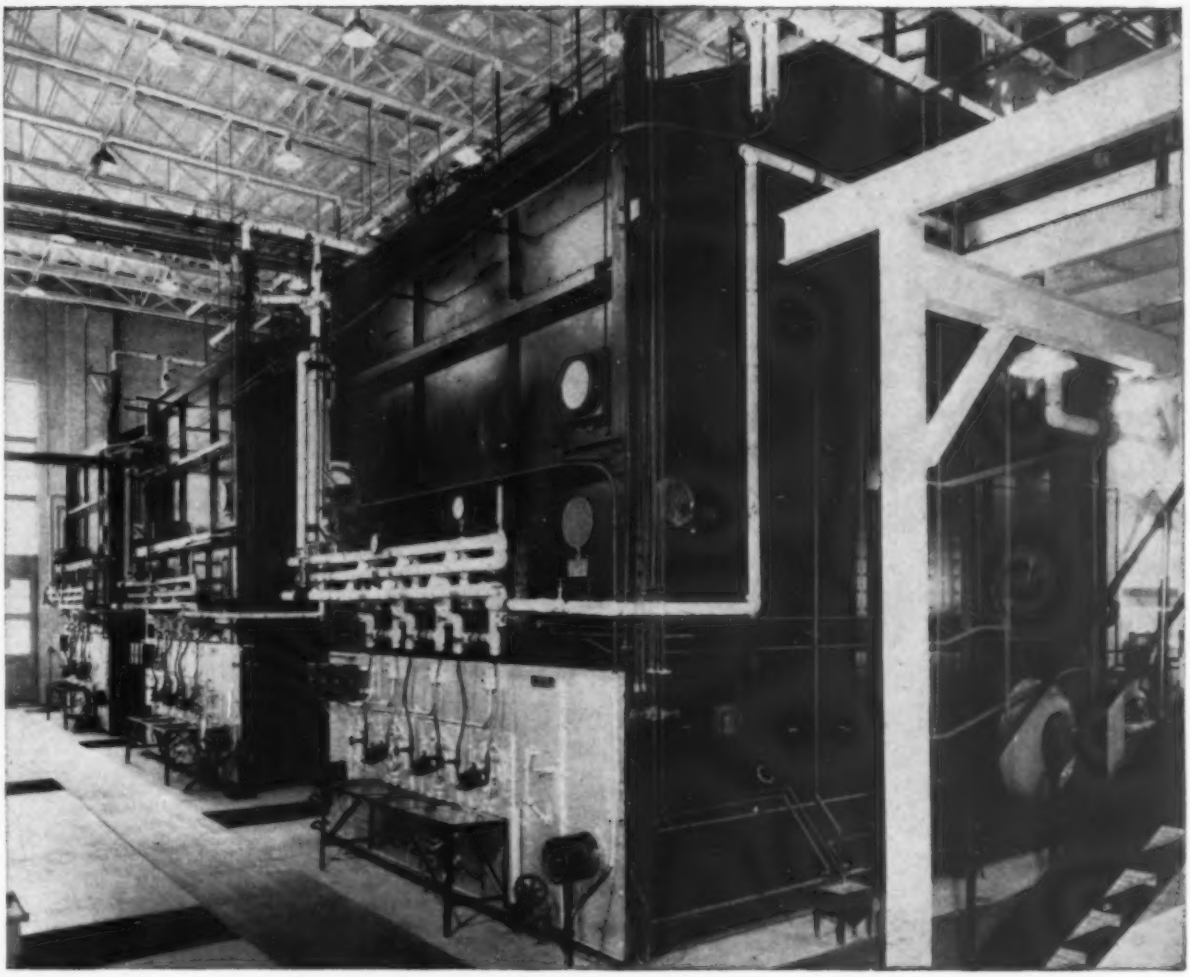
Conference in Africa

Five commonwealth conferences of tuberculosis workers have been held in the past in London, England. The sixth is to be in Ibadan, Nigeria, March 26 to 31, 1962. This sixth conference is being sponsored, as were the others, by the Chest and Heart Association for the Prevention of Tuberculosis. Among the speakers will be eminent chest physicians from Great Britain and all parts of the world.

T.B. Forms Major Problem in India

At the recent conference of the International Union Against Tuberculosis, Dr. T. J. Joseph of India, said there are an estimated 6 million cases of tuberculosis in his country, 600,000 of whom die annually. In fact, one Indian dies from this disease every minute.

A study carried on in Madras by Dr. Wallace Fox revealed that home treatment of patients was just as effective as treatment in sanatorium. Infection of contacts, which had been the greatest fear in home treatment, proved in fact to be less than among those treated in sanatorium. Surprisingly, the poor nutrition, housing, nursing and rest available to home patients had no effect on the course of treatment in comparison with hospitalized patients, who received better treatment in all these categories. The two groups did equally well during a year's treatment and two years' follow-up. In some respects the home patients seemed better off, because treatment disrupted their family life and social environment less.



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A.C.H.A. Activities

THE election of Arnold L. Swanson, M.D., as a regent of the American College of Hospital Administrators was announced at the society's general membership assembly in Atlantic City, N.J., on September 25.

Dr. Swanson is the executive director of the University Hospital at the University of Saskatchewan in Saskatoon. He will represent the College and its affiliates in Region 16, an area embracing the provinces of Alberta, British Columbia, Manitoba, the Northwest Territories, Saskatchewan and the Yukon Territory. This region was formerly represented by Donald R. Easton, M.D., former superintendent of the Royal Alexandra Hospital in Edmonton, Alta.

Born in Red Deer, Alta., in 1918, Dr. Swanson attended the University of British Columbia, McGill University and Northwestern University. Following a number of years in medical staff service, he joined the staff of the Canadian Hospital Association as executive director between 1952-1954. During that time he was also assistant professor in hospital administration at the University of Toronto.

Dr. Swanson has been a member of the College's regional committee, a member of the initial planning committee for the society's congresses on administration, a delegate to the American Hospital Association, a member and president of the Saskatchewan Hospital Association and a surveyor on the Canadian Council on Hospital Accreditation.

Canadians Honoured by College

A second list of Canadians (see *Canadian Hospital*, October, 1961, for first list) honoured by the American College of Hospital Administrators has recently been made available.

Members

Mrs. Yolande Taylor
Montreal, Que.

Bernard Snell, M.D.
Edmonton, Alta.

Nominees

David Beaulieu, M.D., medical director, Sanatorium Ross, Gaspé, Que.

William S. Beck, Goose Air Base, Goose Bay, Labrador.

Bianca M. Beyer, superintendent, The Runnymede Hospital, Toronto, Ont.

Dorothy D. Bowden, administrator, Norfolk General Hospital, Simcoe, Ont.

John W. Brydges, business manager, Woodstock General Hospital, Woodstock, Ont.

Sr. Catherine Charles, superior, Halifax Infirmary, Halifax, N.S.

Sr. Celestine Allard, administrator, Hôtel-Dieu de Saint-Joseph, Tracadie, N.B.

J. Albert Charpentier, administrator, Hôtel-Dieu de Sherbrooke, Sherbrooke, Que.

Gerald A. Cox, assistant administrator, Kitchener-Waterloo Hospital, Kitchener, Ont.

Brig. Mabel H. Crolly, superintendent, Grace Hospital, Windsor, Ont.

Dorothy E. Doan, administrator, Strathroy General Hospital, Strathroy, Ont.

Christopher J. Doherty, M.D., medical superintendent, Sudbury and Algoma Sanatorium, Sudbury, Ont.

Sr. Estelle Arseneault, administrator, Hôtel-Dieu de St. Joseph, Campbellton, N.B.

Noreen M. Flanagan, administrator, Medicine Hat Municipal Hospital, Medicine Hat, Alta.

Gordon Frith, administrator, Nanaimo General Hospital, Nanaimo, B.C.

Zbigniew Gorecki, M.D., medical superintendent, St. Lawrence Sanatorium, Cornwall, Ont.

Raymond A. Jones, assistant superintendent, St. Thomas Elgin General Hospital, St. Thomas, Ont.

William B. Jones, assistant superintendent, Saskatoon City Hospital, Saskatoon, Sask.

Edward H. Knight, administrator, Prince Rupert General Hospital, Prince Rupert, B.C.

Ray E. Krock, administrator, Anson General Hospital, Iroquois Falls, Ont.

Arthur S. Lightfoot, administrator, Campbell River District General Hospital, Campbell River, B.C.

Eugene F. Macdonald, assistant administrator, Burnaby General Hospital, Burnaby, B.C.

Sr. Marie Rose-Blandine, superior and administrator, Laflèche Hospital, Grand'Mère, Que.

Finlay McKerracher, M.D., assistant director (services), Ottawa Civic Hospital, Ottawa.

James A. McMillan, administrator, Surrey Memorial Hospital, North Surrey, B.C.

Hazel F. Naudett, superintendent, The Listowel Memorial Hospital, Listowel, Ont.

Frank J. Porth, M.D., medical superintendent, North Battleford Indian Hospital, North Battleford, Sask.

Sr. Rose Marie, St. Joseph's General Hospital, Little Current, Ont.

Sr. M. St. Anthony, administrator, St. Joseph's Hospital, Chatham, Ont.

John W. Short, assistant administrator, Sarnia General Hospital, Sarnia, Ont.

Mrs. Esther L. Spencer, administrator, Huntsville District Memorial Hospital, Huntsville, Ont.

Frederick S. Woodcock, administrator, Parkwood Hospital, London, Ont. ■

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Resolutions Adopted by the Associated Hospitals of Manitoba

October 4, 1961

Financing New Construction

WHEREAS provincial regulations now provide that new hospital facilities be financed 20 per cent from voluntary sources and 80 per cent by the government of Manitoba;

WHEREAS the government portion is financed first from government grants with the balance coming from debentures sold in the name of the hospital and guaranteed by the province, and

WHEREAS the debentures principal must be repaid by the hospital out of depreciation funds over 20 or 25 years, and

WHEREAS some hospital buildings are depreciated over a 50 year period which does not provide sufficient funds to repay the debenture principal, and

WHEREAS this method of financing hospital construction is not actuarily sound;

THEREFORE, BE IT RESOLVED that this problem be overcome by the government of Manitoba adopting either of the following courses:

Make up the 80 per cent government portion entirely from federal and provincial grants.

Increase the rate of depreciation on buildings to coincide with the debenture terms.

Investment of Depreciation Funds

WHEREAS regulations regarding funding of depreciation restricts investment to deposits in chartered banks, securities of or guaranteed by the government of Manitoba, securities of or guaranteed by the government of Canada, and

WHEREAS it is often possible to earn interest at higher rates on trust company certificates or other investments which qualify under the Trustee Act of Manitoba;

THEREFORE, BE IT RESOLVED that regulations be changed to permit hospital boards to invest depreciation funds in securities which qualify under the Trustee Act of Manitoba.

Hospital Construction and Renovation under Winter Works Program

WHEREAS hospital construction and renovation are now excluded from provincial and federal governments' assistance under the winter works program, and

WHEREAS the provision of hospital facilities benefits all citizens;

THEREFORE, BE IT RESOLVED that hospital construction and renovation be included for federal and provincial assistance under the winter works program.

Construction Grants

WHEREAS the cost of hospital construction has risen during the past five years to the point where $2,000 per bed from each of the senior governments represents a portion as low as 25 per cent of the total cost of new hospital beds, and

WHEREAS many of the service areas such as laundry and dietary are excluded from the construction grant formula, and

WHEREAS the total federal construction grant appropriation for the province is inadequate to meet the hospital construction needs in the province;

THEREFORE, BE IT RESOLVED:

THAT the per bed construction grants from the federal and provincial governments be increased considerably.

THAT the per bed equivalent formula for construction grants be expanded to include service areas now excluded such as laundry and dietary.

THAT the federal appropriation to the province for hospital construction grants be increased in line with the construction and renovation requirements.

Boarder Babies

WHEREAS the hospitalization of babies of unmarried mothers is paid for by the Manitoba Hospital Services Plan for 14 days, and

WHEREAS the number of babies who stay in hospital beyond the 14-day period continues to be a major problem, and

WHEREAS this situation has created a bad debt problem for hospitals, and

WHEREAS the care of these babies is considered a public welfare charge;

THEREFORE, BE IT RESOLVED that the Department of Health and Public Welfare be requested to assume financial responsibility for the hospitalization of boarder babies.

Notification of Per Diem Rates

WHEREAS hospital budgets are required to be submitted to the Manitoba Hospital Services Plan by October 15 each year, and

WHEREAS hospitals are advised of their daily rates nine to 12 months later,

WHEREAS this situation makes hospital financing most uncertain;

THEREFORE, BE IT RESOLVED that hospitals be advised of their daily rates prior to the beginning of the fiscal year.

Notification of O.P.D. Grants

WHEREAS the out-patient departments in teaching hospitals are financed by provincial grants, and

WHEREAS the teaching hospitals are not advised of the amount of O.P.D. grants until several weeks after the in-patient rate is set, and

WHEREAS this situation causes difficulty in budget appeal and in financing;

THEREFORE, BE IT RESOLVED that hospitals be advised of their O.P.D. grants at the same time as their in-patient rates.

Establishment of Per Diem Rates

WHEREAS it has been the policy of the Hospital Plan to advise all hospitals of their rates of payment at the same time, and

WHEREAS this policy contributes to the delay in notifying hospitals of their daily rates;

THEREFORE, BE IT RESOLVED that hospitals be advised of their daily

(continued on page 74)

The most convenient and most accurate infant formula now available!

Farmer's Wife Prepared Formula

with added Vitamins C and D

Next time you prescribe an infant feeding, consider the advantages of Farmer's Wife Prepared Formula—ready for baby's bottle with the one simple addition of boiled water.

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Farmer's Wife Prepared Formula has been tested thoroughly and successfully by pediatricians and hospitals, and by a large panel of mothers. It has proved to be exceedingly well balanced, to suit the majority of normal children. Consider safe, accurate, easy Prepared Formula when prescribing feedings for your youngest patients.

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Whole Milk
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Skimmed Milk

Farmer's Wife

CANADA'S PREMIUM INFANT FORMULA MILKS

A. H. of M. Resolutions

(continued from page 70)

rates individually as they are calculated.

Associated Hospitals of Manitoba Counselling Services

WHEREAS the Associated Hospitals of Manitoba have recently begun a counselling service for member hospitals;

THEREFORE, BE IT RESOLVED that the support and co-operation of the government of Manitoba and the Manitoba Hospital Services Plan be requested.

Equipment Approvals

WHEREAS hospitals are required to obtain approval for all capital purchases for individual items costing in excess of $1,000, and

WHEREAS approvals from the Manitoba Hospital Services Plan are often delayed for several weeks, or months;

THEREFORE, BE IT RESOLVED that requests for approval be dealt with and communicated to hospitals promptly.

Construction Change Orders

WHEREAS the Manitoba Hospital Services Plan require that they approve all construction change orders, and

WHEREAS this policy causes undue delay in construction progress;

THEREFORE, BE IT RESOLVED that responsibility for approval of construction change orders be restored to hospitals within the construction budget.

Education Programs

WHEREAS it has been the practice to support a broad range of education for hospital personnel under the Dominion-Provincial Grant Program, and

WHEREAS it is now planned to reduce this program substantially, and

WHEREAS a reduction in this aid to education programs will restrict the number of persons taking special education;

THEREFORE, BE IT RESOLVED that the federal and provincial governments be urged to continue the existing program of support.

M.M.S. Payments to Hospitals

WHEREAS beneficiaries under Manitoba Medical Service are entitled to diagnostic services when provided by a physician, and

WHEREAS all diagnostic services are not available in all physicians' offices, and

WHEREAS some diagnostic services are only available in hospitals; and

WHEREAS this policy has resulted in misunderstanding and unfavourable public reaction between public and hospitals, and

WHEREAS most hospital employees are beneficiaries under Manitoba Medical Service and are unable to utilize hospital services conveniently available;

THEREFORE, BE IT RESOLVED that Manitoba Medical Service begin making payments to hospitals for diagnostic services.

Accreditation of Small Hospitals

WHEREAS Canadian hospital accreditation standards provide a valuable service in the determination of quality of patient care provided, and

WHEREAS smaller hospitals in Manitoba are not now eligible for accreditation due to size or medical staff complement, they desire a similar guide that will assist them to provide improved patient care;

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba convey to the Canadian Council on Accreditation, our wishes in this regard, and further, request that they endeavour to develop an approved accreditation program in which the smaller hospital will be eligible to participate.

Medical Staff in Small Hospitals

WHEREAS many small hospitals encounter difficulty in assessment of medical staff qualifications and the privileges that may be accorded commensurate with given qualifications, and

WHEREAS due to a small medical staff it is not always possible to establish an adequate medical staff committee to effectively conduct a program of self-discipline, and

WHEREAS this situation could and does leave the hospital with no alternate steps, should such be desired;

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba, through its liaison with the Manitoba Medical Association, jointly develop, in the near future, a service to which small hospitals may refer such problems for assistance.

Nursing Staff

WHEREAS registered nurses, licensed practical nurses and student nurses at all levels of experience are classified as being equivalent for providing nursing service by M.H.S.P. in establishing rates for hospitals, and

WHEREAS the use of auxiliary personnel in the care of the sick is only safe when there is provision for adequate supervision by a professional worker and,

WHEREAS the hours of services provided by student nurses must be safeguarded for educational purposes, if they are to meet present-day standards, and

WHEREAS the capacities of students should vary according to their levels of experience, and

WHEREAS adequate supervision of students is necessary for safety;

THEREFORE, BE IT RESOLVED that the Manitoba Hospital Services Plan give consideration to all these factors in negotiating, with hospitals, adequate levels of nursing service and categories of personnel to fill them (Carried as amended.).

Alternate Regional Representatives

WHEREAS circumstances sometimes prevent the elected representative of the hospital region from attending the monthly meeting of the Associated Hospitals of Manitoba or a hospital regional meeting, and

WHEREAS it is important that this region have an official representative at all such meetings, and

WHEREAS it is possible that, through uncontrollable circumstances, the elected regional representative may not be able to continue the office because of leaving the hospital field, moving to another area, or other reasons, and

WHEREAS the region would not, therefore, be represented at meetings of the Associated Hospitals of Manitoba, until another representative were elected;

THEREFORE, BE IT RESOLVED that the regions request an addition to by-laws of the Association to permit the election of an alternate regional representative, and further that the nominating committee of the regions consider such election at their annual regional meetings.

Public Relations Program

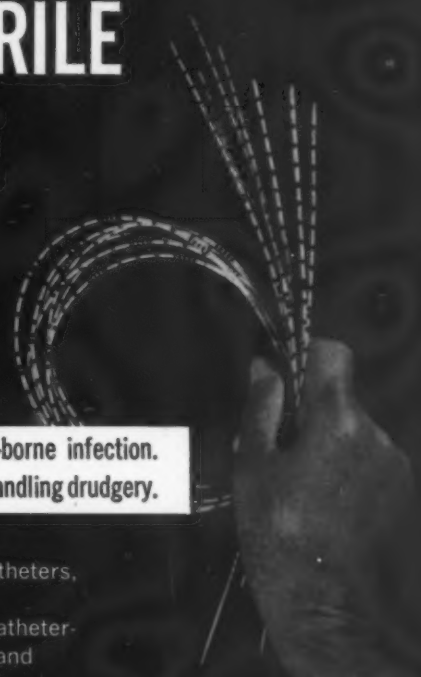
WHEREAS the opportunities do exist for hospitals, regional councils, and the Associated Hospitals of Manitoba, to improve upon public relations, and

WHEREAS the public must continue to be informed, if it is to maintain an interest in hospitals;

THEREFORE, BE IT RESOLVED that member hospitals, regional councils and the Associated Hospitals of Manitoba make every effort to adopt a comprehensive public relations program, and further that member hospitals submit a copy of local press clippings to their provincial association for the purpose of evaluating the public relations program.

(continued on page 76)

NEW A.C.M.I. STERILE DISPOSABLE URETERAL CATHETERS



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(concluded from page 74)

Minutes of Regional Meetings

WHEREAS the board of trustees and administrative staff of each hospital should be well informed on the details of each regional meeting;

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba, as acting secretary for the regional meetings, supply copies of the minutes of such meetings to each hospital, as soon as possible after such meetings.

M.H.S.P. Registration Numbers in Rural Hospitals

WHEREAS the Manitoba Hospital Services Plan has taken steps, for Metropolitan Winnipeg hospitals, to improve the service for securing M.H.S.P. numbers, and

WHEREAS this problem continues to be of major concern to rural hospitals;

THEREFORE, BE IT RESOLVED that the Manitoba Hospital Services Plan be requested to review this problem, in order to provide the fastest possible service, such service not to exceed 48 hours.

Variation in Hospital Personnel Policies

WHEREAS much confusion has arisen over past years by the disallowance of certain locally established personnel policies, and

WHEREAS a recent survey conducted by the Associated Hospitals of Manitoba indicates variation in existing policies throughout the province, and

WHEREAS standardization may not be in the public interest;

THEREFORE, BE IT RESOLVED that the Manitoba Hospital Services Plan be advised of the wisdom of accepting costs involved by existing policies, where variations are limited or realistically required.

Trustee Institute

WHEREAS it is desirable that newly-appointed trustees, particularly, be given the opportunity to acquire knowledge of their responsibilities, the organization and objectives of hospitals, and other matters relating specifically to hospitals, and

WHEREAS such opportunities are, at present, very limited,

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba organize and sponsor a hospital trustees' institute, not to exceed two days, early in 1962.

Education of Non-Professional Department Personnel

WHEREAS there is a need for better-trained personnel in service departments within hospitals, and

WHEREAS it is recognized that training courses for such personnel are limited, at present,

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba accelerate the programs to train staff of hospitals.

Standby Emergency Power Facilities

WHEREAS a survey conducted by the Associated Hospitals of Manitoba indicates a definite need for standby emergency facilities in almost all hospitals;

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba approach the provincial government to stress this need and obtain whatever assistance is possible to finance such facilities, and further that an approach also be made to the civil defence authorities to obtain their support.

Collection System for Non-Residents

WHEREAS collection of hospital claims for beneficiaries of other provincial hospital plans and transients causes difficulty and delay in settlement;

THEREFORE, BE IT RESOLVED that M.H.S.P. establish a collection system for such claims, thereby enabling hospitals to look only to M.H.S.P. for payment of all accounts of Canadian residents.

Appreciation to Metropolitan Hospitals

WHEREAS it is appreciated by rural hospitals that the services of the Associated Hospitals constitute a greater benefit to them than the larger metropolitan hospitals, and

WHEREAS, without the active support, both financial and otherwise, of the larger hospitals, many of the present services given would not be possible;

THEREFORE, BE IT RESOLVED that this meeting express appreciation to boards of the larger institutions, for their support and co-operation in the Association's activities.

M.H.S.P. Arrangements with Northern Hospitals

WHEREAS hospitals in the northern part of Manitoba, because of their geographic position, have problems which are not common to southern Manitoba, and

WHEREAS determination of per diem compensation by Manitoba Hospital Services Plan is established for these hospitals by reference to the costs of more southerly hospitals, and

WHEREAS the cost of operation of northern hospitals is unavoidably higher than other hospitals of equal size due to transportation costs, necessary incentives to obtain and hold staff,

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba recommend to the rate setting authority within Manitoba Hospital Services Plan that careful consideration be given to establishing a formula of payment which will be more equitable than the present practice of basing per diem payments on the average costs of southerly hospitals of equal size.

Loans to Student Nurses

WHEREAS the amount of loans available to student nurses in Manitoba from the provincial government have been deemed to be inadequate by the Manitoba Association of Registered Nurses, and

WHEREAS the Manitoba Association of Registered Nurses is approaching the provincial government to have the amount of its loans increased;

THEREFORE, BE IT RESOLVED that the Associated Hospitals of Manitoba express its support of the action to be taken by the Manitoba Association of Registered Nurses.

Thanks

BE IT RESOLVED that the Associated Hospitals of Manitoba record appreciation and thanks to the speakers who have contributed so much to the success of this meeting; to the exhibitors whose displays have added greatly to the information and interest of delegates; to the manager and staff of the Royal Alexandra Hotel for their excellent arrangements; to the press whose reporters have been in attendance each day; and to the Canadian Hospital Association and the professional associations of the province of Manitoba whose co-operation has resulted in the outstanding success of this 10th Annual Manitoba Hospital and Nursing Conference, and

To the W. K. Kellogg Foundation for its financial support and assistance in the development of important programs directed toward the improvement of hospital services in Manitoba.

BE IT RESOLVED that the membership of the Associated Hospitals of Manitoba express their appreciation and thanks for the efforts of the officers, directors and staff of the Association during the past year. ■

Manitoba Conference

(concluded from page 47)

ed that the motto of the provincial association of hospital auxiliaries is now "Know your Hospital."

A second panel, with J. E. Robinson as moderator, comprised representatives of local communications media. Public relations was defined as planned communication which must be designed to appeal to various publics. The discussion ranged through informative pamphlets for patients and visitors, hospital tours, volunteer training, annual reports, and the importance of good press relations.

A.H. of M. Annual Meeting

In his presidential report to the annual meeting William T. Andrew, Hamiota, outlined the many activities and accomplishments of the association during the past year. The board of directors met monthly and minutes of these meetings were sent out to all chairmen of hospital boards. The *A.H.M. News Bulletin* which had to be suspended for a time is to be revived. In the report accounting program, 57 hospitals are now included — an increase of eight over 1960. The aim is to reach 65 smaller hospitals which are eligible.

With respect to the group insurance project, Mr. Andrew announced that as of October 1st the 75-per-cent-of-employees requirement had been removed. Hospitals must still make this insurance a condition of employment for all new employees. Up to October 1st, 32 hospitals had been enrolled.

Mr. Andrew reported delay in achieving a proposed pension plan for employees. The plan had been approved at the federal level and the association is waiting for action by the Manitoba Hospital Services Commission.

He noted the establishment on August 1st of a counselling service and the appointment of Charles Grierson as director of this service.

A study on group purchasing is being carried out for the information of member hospitals. A comparison of costs on approximately 200 items is under way and the speaker hoped that a report would be ready within a few weeks.

Concerning relations with the M.H.S.P., Mr. Andrew reported that his executive had been able to establish monthly meetings with officials of the Plan. Frank discussions had been held and these had led to much improved understanding and good will.

He discussed in some detail a subject of much concern among hospitals of that province. This was the *Proposed Regulations Under the Hospitals Act Relating to Standards for Licensure* which had been presented in draft form to the association. In turn the association presented a brief to the Minister of Health and Public Welfare, the Hon. George Johnson, and the Commissioner of the M.H.S.P., G. L. Pickering, setting out their views. In essence, it was urged that before legislation is enacted concerning standards, mutually acceptable principles must be developed and applied. Mr. Andrew read in part from the brief:

"We recommend the establishment of a Standards and Licensure Council. . . . The new body would be the co-ordinator and arbitrator between the medical profession, governments and hospitals. It would also act as the accrediting organization for the purpose of evaluating, educating and approving the operation of hospitals on behalf of the provincial government."

It was explained that the proposed body would be responsible for the licensure of all hospitals in Manitoba, it would survey hospitals upon invitation or instruction from the Minister, and would recommend application of a hospital for accreditation by the Canadian Council on Hospital Accreditation. This brief is, we understand, now under consideration.

Mr. Andrew reported on the activities of five hospital regions which he and a team from headquarters had visited; and he urged that every hospital set up an active public relations committee. Give the news you would like to have circulated a chance to travel, he said. He then reviewed the various training courses for hospital personnel which are available in Canada and urged hospitals to take advantage of these in order to have the services of well-trained personnel. Education for every category of hospital worker he deemed important if the hospital is to achieve its purpose and maintain its autonomy.

Officers for Next Year

At this meeting the officers for 1961-62 were elected, as follows: honorary president, Hon. George Johnson; president, G. B. Rosenfeld, Victoria General Hospital, Winnipeg; first vice-president, R. J. Hood, Fox Memorial Hospital, Carberry; second vice president, Dr. Paul L'Heureux, St. Boniface Hospital; honorary secretary-treasurer. Frank Baker, Brandon General Hospital.

Named as directors were: E. Dubinski, Winnipeg; Henry Posyniak, Winnipeg; W. W. Devine, Portage la Prairie; Dr. John Zmetana, Rivers; Major S. Mundy, Winnipeg; E. W. Hawkins, Dauphin; P. E. Swerhone and John McIntyre, both of Winnipeg.

The new officers were formally introduced to delegates at the association banquet. On this occasion, too, life memberships in the association were conferred upon Judge Milton George of Morden and John Gardner of Dauphin. These gentlemen, who were well-known to the audience, were honoured for their many years of voluntary service to the hospitals of Manitoba.

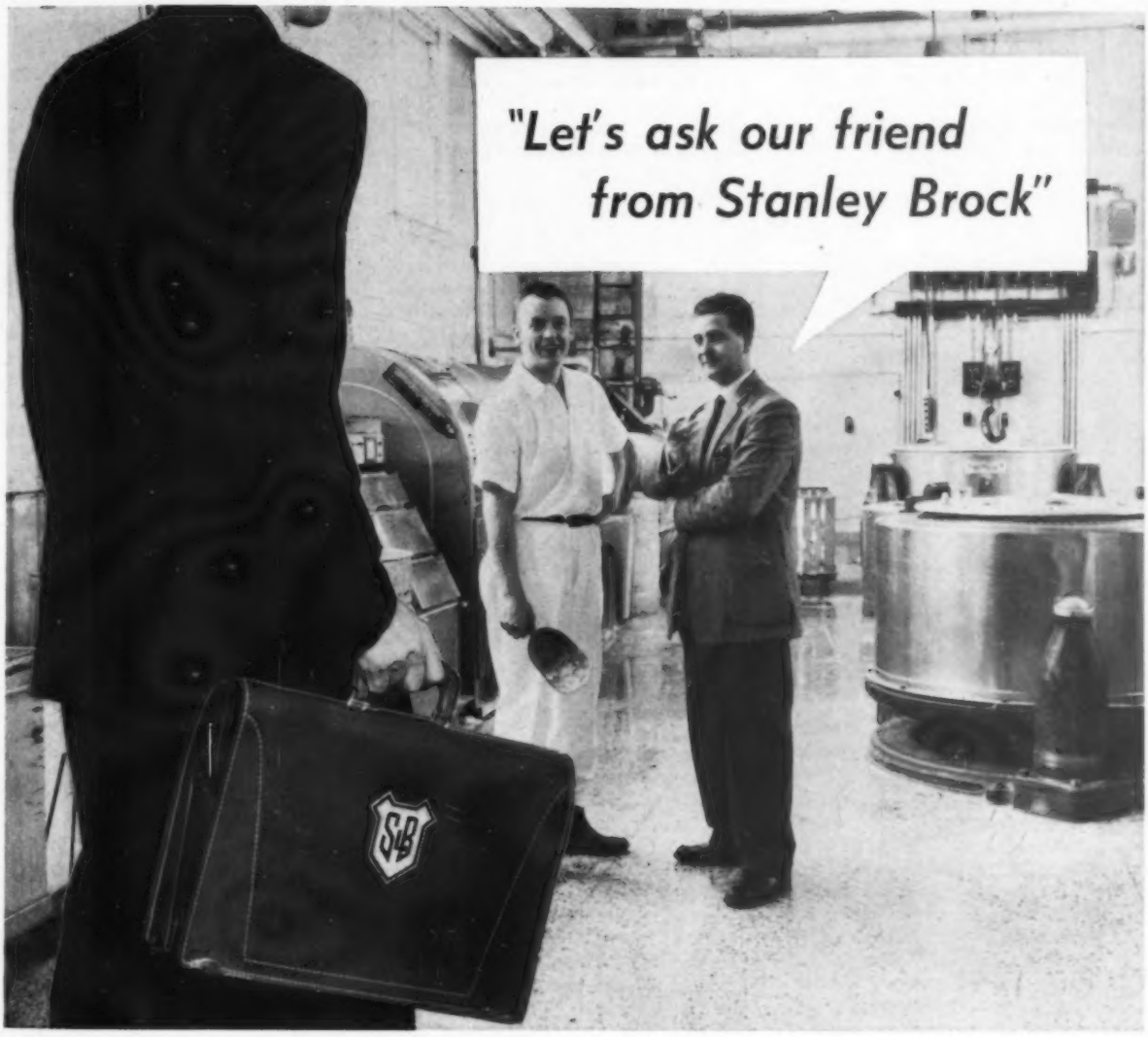
A carefully studied slate of resolutions was submitted to delegates and most of them were adopted. These appear on page 70.

Adolescent Unit Opened in Montreal

The Montreal Children's Hospital in Montreal, Que., is pioneering in the field of medical guidance and care for youth. The hospital recently opened the first "adolescent unit" in Canada — a unit devoted to the medical problems of those who are too old to be classed as children but too young to be treated as adults.

Psychosomatic problems — those that are wholly or partially emotional in origin — are expected to take up a great deal of the time and attention of the unit. One of the doctors on staff, Dr. Peter Benjamin, says that experience has shown that about 60 per cent of adolescent problems have definite emotional content. For this and other rasons, the unit is separated from the rest of the hospital and has facilities for interviews and discussions of emotional problems as well as regular clinical examining rooms.

An important function of the new unit is to act as medical liaison with, and medical advisor to, the various community agencies which concern themselves with adolescents. Another function is to act in a teaching capacity to nurses, medical students, residents and to a number of other disciplines.



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Saskatchewan Meeting
(concluded from page 50)

be subject to grants on the same basis as new construction grants AND THAT items considered as building service equipment either be considered as capital equipment and depreciated, or that grants be given.

● BE IT RESOLVED that the Saskatchewan College of Physicians and Surgeons, in conjunction with the Saskatchewan Hospital Association, consider the establishment of a suitable committee or committees to assist the rural hospital staffs with an audit of practice and to perform such duties as are usually performed by records, tissue and credentials committees and medical advisory boards of departmentalized hospitals.

● BE IT RESOLVED that the Saskatchewan Hospital Association request the Canadian Hospital Association to ask all provinces now providing hospitalization to issue cards showing entitlement to coverage.

● BE IT RESOLVED that the Saskatchewan Hospital Association petition the Ministers of Health and Welfare to make necessary long-term nursing care available to patients — irrespective of age and ability to pay — who do not qualify for admission to geriatric centres.

● WHEREAS the report submitted to the provincial government of Saskatchewan on March 1, 1961, by the Local Government Continuing Committee recommends that the ownership and administration of public hospitals, as well as hospital service, medical care, public health and social welfare services within a region of five or six counties, be transferred to a single board for that region,

THEREFORE BE IT RESOLVED that the Saskatchewan Hospital Association assembled in annual meeting request that the provincial government will not further remove the autonomy of the present hospitals of the province by following this recommendation of the Continuing Committee.

● WHEREAS chronically ill patients who must wait for admission to a geriatric centre or a nursing home are in most cases unable to pay the costs of interim hospitalization, and the hospital concerned is unable to receive compensation from any source for their care,

THEREFORE BE IT RESOLVED that the Saskatchewan Hospital Association petition the provincial government to instruct the Department of Social Welfare to assume the cost of hospitalization for patients who have been discharged by their physician but who still remain in the hospital awaiting admission to a geriatric centre or a nursing home; or to provide alternate care in the interval.

● BE IT RESOLVED that the Saskatchewan Hospital Services Plan be requested to consider broadening the present coverage or benefits allowed on an out-patient basis to include diagnostic work.

● BE IT RESOLVED that any hospital and hospital employees' union contracts be signed and wage increases awarded conditionally on the increased cost of such negotiations being acceptable to the Saskatchewan Hospital Services Plan as legitimate costs of efficient hospital operation, and as such included in Saskatchewan Hospital Services Plan payments to hospitals.

● BE IT RESOLVED that the trustee members of the Saskatchewan Hospital Association executive board, who receive no reimbursement for their time and efforts, be indemnified in some amount to be agreed upon by the Association executive.

● BE IT RESOLVED that the Hospital Rate Board make known to hospitals any changes affecting earnings or disbursements in time for early budgets or otherwise postpone them until the following year.

● BE IT RESOLVED that the Saskatchewan Hospital Association make representation to the Saskatchewan Hospital Services Plan, pointing out the inequity of the fixed allowances arbitrarily allotted for expenditures which vary according to the type of work performed, and requesting that for budgetting purposes, they make extra allowance for the type of services offered.

● BE IT RESOLVED that the Saskatchewan Hospital Association petition the Department of Public Health to allow hospitals to charge a $1 per diem sustenance fee, the full amount to be retained by the hospital.

● BE IT RESOLVED that the Saskatchewan Hospital Association request the provincial government to amend the Saskatchewan Hospitalization Act by providing:

(a) payment to any participating hospital for hospital services rendered on behalf of any resident of Saskatchewan who would otherwise be entitled to benefits provided by the Act but for the non-payment of tax;

(b) that all payments made to a hospital for and on behalf of such person by the province be a debt owing by such person to the province; and

(c) that procedure for the collection of such debt by the province be similar to the procedures used by the federal government in recovery of monies owing to it under the Income Tax Act.

● BE IT RESOLVED that the gratitude of the Saskatchewan Hospital Association be expressed to Michael F. Kushnir of Canora in recognition of his continued and valued contribution to the hospitals of Saskatchewan.

AND BE IT FURTHER RESOLVED that the Association, in recognition of the outstanding service of Mr. Kushnir in the hospital field, bestow upon him the honour of life membership in the Saskatchewan Hospital Association. ■

Coming Events

Nov. 20-24—Canadian Hospital Association Laundry Institute in conjunction with the Maritime Hospital Association, Moncton Hospital, Moncton, N.B.

Dec. 3-6—Regional Institute on Hospital Accounting and Finances, sponsored by the American Association of Hospital Accountants, Hotel Kenmore, Boston, Mass.

1962

June 4-8—Canadian Hospital Association Assembly Meeting and the Western Canada Institute, Jubilee Auditorium, Edmonton, Alta.

June 18-22—Canadian Medical Association Annual Meeting, Royal Alexandra Hotel, Winnipeg, Man.

June 24-29—31st Biennial Meeting of the Canadian Nurses' Association, Vancouver, B.C.

Oct. 29-31—Ontario Hospital Association Annual Convention, Royal York Hotel, Toronto, Ont.

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MOSBY'S COMPREHENSIVE REVIEW OF NURSING. Fifth Edition. Published by C. V. Mosby Co., St. Louis, Mo., 1961. Illus. Pp. 686. Price $7.75.

This is intended to be a study outline for those nurses, student and graduate, who want a clear, authoritative summary of the subjects taught in the basic course in nursing. It will be helpful for examinations and for review purposes. This edition has been revised and brought up-to-date. Accompanying the book is a pamphlet containing answers to the questions posed in the text.

PROCEEDINGS OF THE FOURTH INTERNATIONAL CONGRESS ON CLINICAL CHEMISTRY, Edinburgh, August 14-19, 1960. Published by Butterworth & Co. (Canada) Ltd., Toronto, 1961. Illus. Pp. 212. Price $8.

This volume contains the presidential address, the short abstracts of communications and the papers read at the four plenary sessions. The Congress was organized by the Association of Clinical Biochemists of Great Britain, with the authority of the International Federation of Clinical Chemistry and the International Union of Pure and Applied Chemistry.

PSYCHIATRIC NURSING. Third edition, by Ruth V. Matheney, R.N., Ed.D., and Mary Topalis, R.N., B.S., M.A. Published by The C. V. Mosby Co., St. Louis, Mo., 1961. Pp. 281. Illus. Price $3.75.

With the growing understanding of mental illness and the treatment for it, a whole new range of functions is opened to the nurse in this field. Up to the present time the practice of psychiatric nursing presented a rather confused picture due to the lack of wider knowledge. The purpose of this book is to provide adequate knowledge for the student nurse during the transition period psychiatric nursing is now undergoing. The book is also intended to have some application to the general experience of the student. An attempt has been made to shift the emphasis from understanding psychiatry to understanding the patient. Psychiatric terminology has been reduced as much as possible. The appendix which contains an outline of diagnostic classifications will be of help to those instructors who use it as a frame of reference.

HEALTH PRINCIPLES AND PRACTICE Third edition, by C. L. Anderson and C. V. Laughton. Published by The C. V. Mosby Co., St. Louis, Mo., 1961. Pp. 430. Illus. Price $5.75.

A comprehensive treatment of health principles and practice has been presented in this book, which is set out in a textbook form to serve the needs of a one-year college term in hygiene. The traditional psychological treatment of the subject has been avoided. Results of recent research done in various health problems have been explained. These include such matters as the prevention of rheumatic fever and rheumatic heart disease, the prevention and treatment of atherosclerosis, advances in dental health, problems of air pollution, including radioactivity.

The material has been presented in a very practical way making it useful in a classroom and also as a reference. The various charts, diagrams and illustrations add to the clarity of the subject as well as interest.

THE PUTNAM MEDICAL DICTIONARY by Norman Burke Taylor and Allen Ellsworth Taylor. Published by the Macmillan Co. of Canada, Ltd., Toronto, 1961. Illus. Pp. 933. Price $6.25.

This is a compendium of medical terms adapted to the special needs of students and also to meet the requirements of all practitioners in the health and related fields. The appendix contains many items useful for students: tables giving the names and functions of bones, muscles, nerves and circulatory members of the human body; classifications of communicable diseases; disinfection and sterilization charts; information concerning poisons and antidotes; weight, height and age tables; and a complete coverage of weights and measures.

AN ENGINEER LOOKS AT FALL-OUT SHELTER. Published by Emergency Measures Organization, Ottawa, 1961. Illus. Pp. 145.

Emergency Health Services, Department of National Health and Welfare, consider that this manual will be of interest to hospital administrators, and to their engineering and architectural advisers. Copies may be requested from Regional Federal Emergency Measures Organization Officers.

BLOOD TRANSFUSIONS WITHOUT CONSENT. Published by the Canadian Red Cross Society, 95 Wellesley St. E., Toronto, Ont, 1961. Pp. 22.

This pamphlet is the result of a symposium of the Medico-Legal Society of Toronto on a subject of great importance and timeliness. The Canadian Red Cross Society, as the operator and administrator of the National Blood Transfusion Service in Canada, is making this material available as a public service to hospital administrators as well as members of the medical and legal professions.

DIET AND MENU GUIDE. Published by the Joint Committee of the American Hospital Association and the American Dietetic Association, Chicago, Ill., 1961. Pp. 36. Illus. Price $2.50.

This guide was prepared to assist the non-professional food service manager in smaller hospitals and nursing homes. It discusses, in a simple form, basic principles of nutrition and menu planning, preparation and use of selective cycle menus and menu plans for the normal diet, with modifications for the most commonly used therapeutic diets. Detailed examples of all the diets and menu plans discussed illustrate the text.

No Hurry

Robert Benchley was drinking martinis mixed with second-rate gin one day when a friend passed by. "Don't you know," warned the friend anxiously, "that stuff's slow poison?" "Oh, that's all right," said Benchley, "I'm in no hurry."

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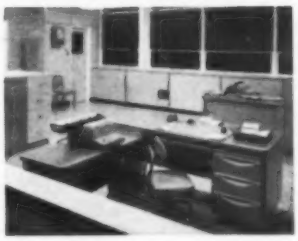

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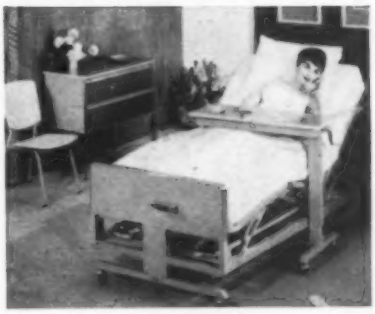

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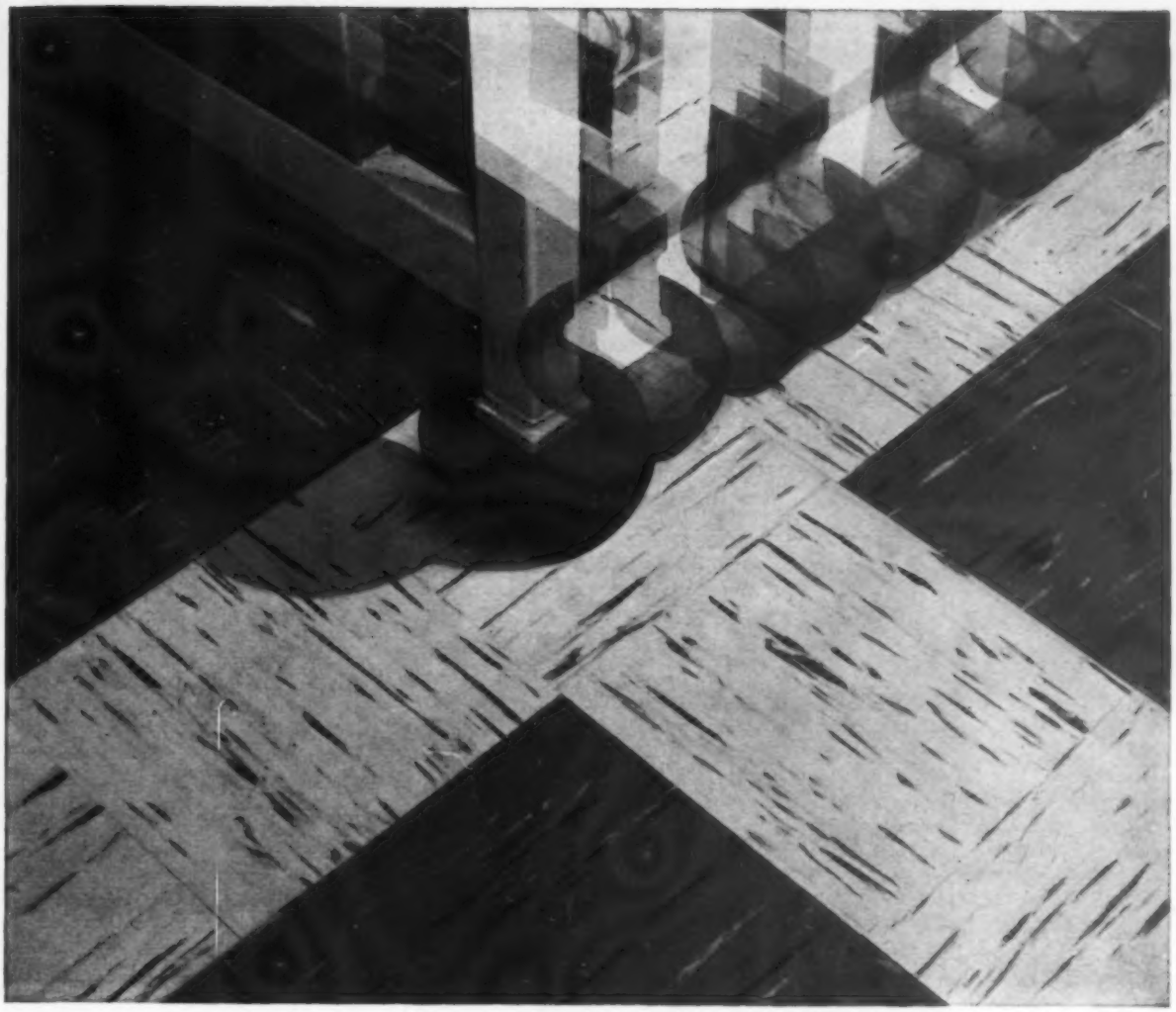

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1962 Canadian Hospital Convention

As in 1957, another Canadian hospital convention will be held in 1962. It will take place in the Northern Alberta Jubilee Auditorium, Edmonton, Alta., June 4 to 8. At this time the 19th Assembly meeting of the Canadian Hospital Association will be combined with the 17th Western Canada Institute for Hospital Administrators and Trustees, under the sponsorship of the Associated Hospitals of Alberta. Further information will be published as the program is developed. All hospital people are invited and we suggest that you make your plans to attend now.—Edit.

Administrative Control

(continued from page 42)

can be revealing. The difference in length of stay among patients of various physicians for the same condition may vary by as much as 100 per cent. When the chief of a service has such information at his disposal, he is in a position to take necessary action, thus helping to make the most effective use of the hospital's beds, its facilities and its services.

Pride, Prestige and Politics

All too frequently the characteristics which are responsible for unnecessary hospital costs are pride, prestige and politics. There are few politicians who can resist the well intentioned desire of public-spirited citizens who wish to establish a hospital, particularly if said citizens are also constituents. Frequently the beds planned are unnecessary, either because a hospital already exists reasonably close to the planned one, or because they do not represent the kind of beds (long-term, convalescent, active treatment) required. We should remember that on the average, a 100-bed general hospital will cost $2,000,000 to build and about $750,000 annually to operate. While we have a responsibility to provide adequate hospital facilities, it is imperative that they represent the right bed in the right place at the right time.

The right bed involves, firstly, determining whether the area in question requires active treatment beds in a general hospital (the most expensive to construct and to operate), or whether the provision of beds for long-term diseases, convalescent care, custodial care in a nursing home, a home care program, or a combination of any of these will relieve the pressure on existing active treatment general hospital facilities.

By right place we mean, not only a proper location which is central to the trade and residential area the hospital is designed to serve, but also the right size of hospital. It is economically unsound to build small hospitals of 100 to 200 beds within a few miles of each other, when one larger institution of 400 to 500 beds would suffice and provide better care at a lower unit cost. In addition to avoiding duplicate administration and overhead costs, the purchasing power of the larger hospital will effect substantial savings. It will also attract competent department heads because it is able to pay higher salaries. As a result, not only is a better job done, but more value is received for the money spent.

By right time we mean providing the beds needed today and anticipating, insofar as is possible, future requirements. Inadequate planning has resulted in construction for yesterday's needs and consequently, the new hospital is obsolete the day it is opened.

Another costly problem is the desire to provide services and equipment because of the supposed prestige which this brings to the institution or the selfish desires of vocal members of the medical staff. Of course, each hospital should have the equipment which it requires to do its job, but it appears that equipment and services are required not because they are needed, but because they have become status symbols.

A good example of this is the electro-encephalograph which in many hospitals is used two days of the week and for one or two hours each day. We know of one institution which, several years ago, purchased an artificial kidney but has never used it — not because it has not been needed, but because the medical and nursing skills necessary for its operation were not available in this hospital. We question whether a group of hospitals located within a few miles of each other should each have a heart-lung machine costing approximately $50,000, or heart surgery equipment costing more than $100,000, or a cardio pulmonary laboratory with about $60,000 worth of equipment in it. The needs of all of these institutions could be served if these units were located in one hospital and used intensively. Not only would capital costs be decreased, but so would operating costs. To accomplish this requires the planning of an interrelated hospital system. It also requires a changed concept of the medical staff appointments to permit all *qualified* specialists to avail themselves of the use of the equipment and services. Such a change is long overdue. The closed staff hospital has been "too closed" and the open staff hospital "too open".

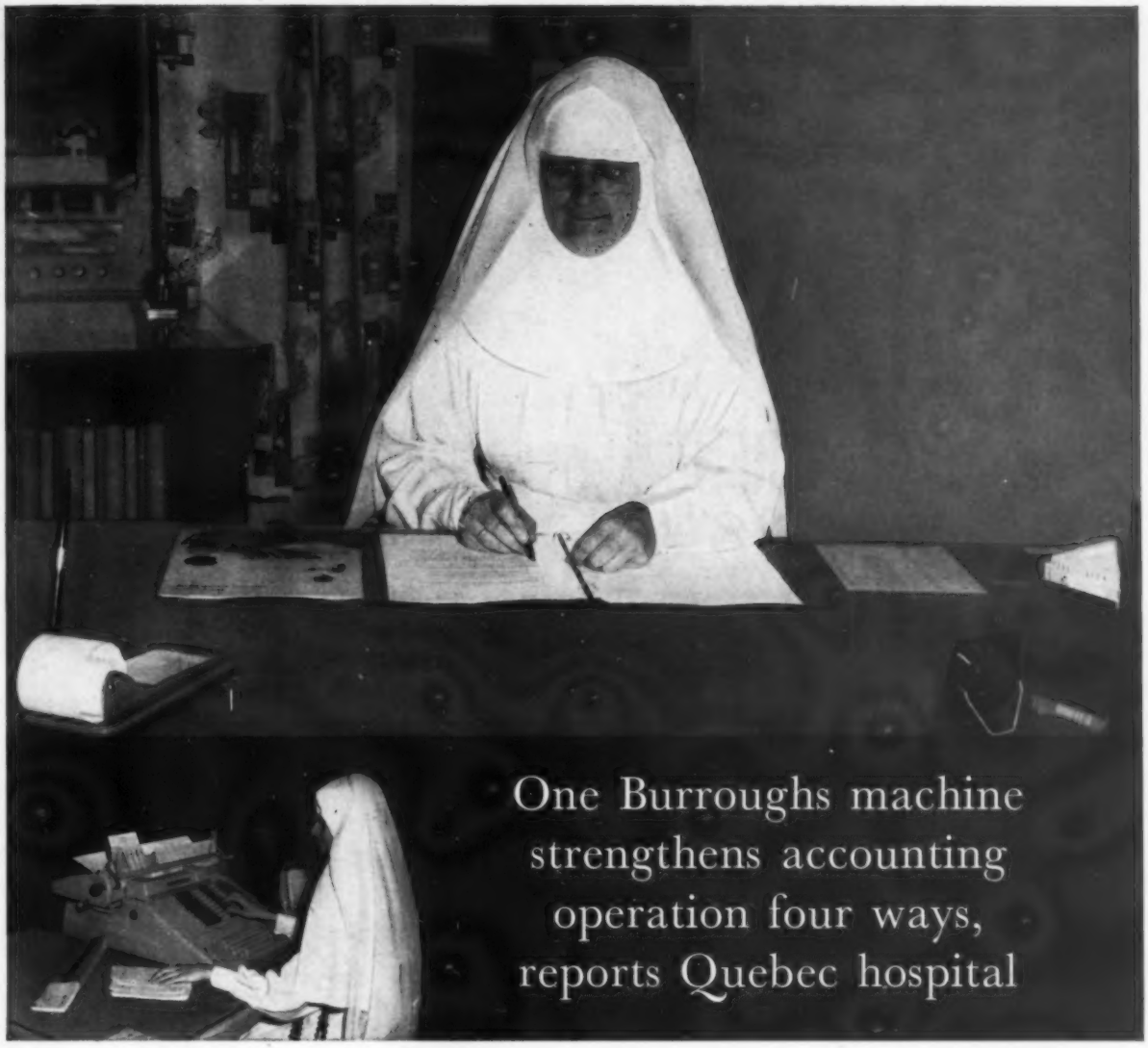
Additional examples of co-operative ventures which would reduce costs or improve services, or both, are the joint use of a steam plant, as is now being done by a group of hospitals in Toronto. They are also planning to investigate the feasibility of group purchasing as a means of reducing costs. A central statistical service using the latest in tabulating equipment and trained personnel, something few hospitals can afford, would relieve hospitals of this function and permit them to reduce personnel accordingly. A continuing program of method improvement which would indoctrinate key people in each institution with ways, means and tools involved in work simplification could not help having favourable results.

Summary

The last few years have seen drastic changes in the field of hospital financing in Canada; the most radical one being the assumption by governmental agencies of virtually the whole of the hospital insurance field. This has broadened the responsibility of hospital financial administration to include accountability to the whole community as represented by these governmental agencies. A duty is placed upon hospital management to justify the spending of the funds placed at its disposal. If such justification is to carry conviction, it must demonstrate beyond any reasonable doubt that expenditures are being effectively controlled and wisely planned.

We have attempted to outline some of the areas in which we can affect hospital costs. Admittedly,

(concluded on page 88)



The scene: Arthabaska Hospital, Arthabaska, Quebec. The hospital uses one Burroughs F 1500 Typing Accounting Machine on accounts payable, general ledger, expense reports, payroll and inventory control. Sister Rodrigue outlines the four points of improvement:

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Control

(concluded from page 86)

the implementation of some of the suggestions will require courage — the courage to say "NO" to potential voters; to formulate an integrated hospital system; to avoid the kind of egotism that results in costly duplication of services and equipment; to adjust our medical staff appointment system so that we will not deprive the public of the services of qualified physicians — all of these require courage and the will to do them. Hospital administrators and trustees should be satisfied with nothing less. ■

Brochure Available on Intensive Patient Care

Now being circulated by the W. K. Kellogg Foundation to 15,000 hospital and medical personnel in the U.S.A., Canada, Europe, Australia, and Latin America is a brochure regarding the special care unit operated by Community Hospital of Battle Creek, Mich.

This publication, entitled, "The Planning and Operation of an Intensive Care Unit", is intended to assist hospitals generally in considering whether such a concept of patient care could be advantageously applied to their particular situations. Intensive patient care involves the concentration within one hospital area of selected patients requiring particular nursing skills, of life saving equipment and drugs, and around-the-clock observation and therapy, and represents a partial answer to the shortage of private duty nurses available for the critically ill.

Animal Study on Air Pollution

The U.S. Public Health Service has announced that it will undertake a large-scale animal study designed to examine the possible effects of air pollution on human health. Researchers at Wayne State University College of Medicine in Detroit, Mich., will study more than 4,000 experimental animals with particular emphasis on pulmonary function, length of life, blood studies, and pulmonary pathology. The animals will be divided into three groups, the first of which will breathe exhaust-contaminated air from a heavily travelled street. The second group will be exposed to the normal urban air present in the laboratory. The third group will be housed in a room containing specially cleansed air from which almost all impurities will have been removed.

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Psychological Problems

(concluded from page 49)

cess through which medical and other students pass. As this is a defense against situations too painful to be borne, it was thought that hospitals could be more alert to this process in order to help students and protect patients. The use of patients for teaching and research purposes was considered particularly hazardous to emotional health and it was suggested that chiefs of staff must be sensitive to this. There was general agreement that patients should not be used for teaching purposes against their will.

The relationship of the doctor to the hospital chaplain appears to be the subject of study in all countries represented at the meeting. Although no strong opinions were expressed it was felt that the spiritual adviser should have a very real place in the hospital rather than being called only to the gravely ill. It was felt also that he should be a spiritual adviser not a psychological counsellor *per se* although it was recognized that the two rôles overlap at times.

During discussion of assignment of patients it appeared that what is best for hospital and for staff is not always best for the patient and vice versa. For instance, moving patients, in stages, from intensive to partial self-care units often causes a few days of depression. Patients do not like being moved. Insisting that convalescent and chronically ill patients be treated in separate institutions may mean that students only gain experience in caring for acutely ill patients. Patients may respond better when with their own age group but this can mean having surgical and medical patients in the same ward and result in inefficient use of equipment.

Future Action

The co-ordinator of study groups, Elizabeth Barnes, is now engaged in producing a final publication, *People in Hospitals*, aimed at individuals concerned with general hospitals. It is being published by Macmillans and should be available here shortly.

All groups expressed interest in continuing the study, while they could still capitalize on present interest, but it was recognized that there could be difficulties related to time and availability of personnel. The Ottawa Study Group feels that further study should be undertaken by committees located in the participating hospitals with, possibly, a co-ordinating committee composed of representatives from each hospital group. No action has been taken on this recommendation to date although consideration is being given to appropriate local sponsorship. ■

Report of Ottawa Study Group on Psychological Problems in General Hospitals. Ottawa, 1960. Copies may be secured from: Canadian Nurses' Association, 74 Stanley Ave., Ottawa; Canadian Mental Health Association, 11½ Spadina Road, Toronto 4, Ontario; Mental Health Division, Department of National Health and Welfare, Ottawa.

Purpose

Writing is only serviceable and good with reference to the object for which it is written. You say: "That is a beautiful dress"; but let the dress slide from the model's shoulders and lie in a heap on the floor, and what is it? A heap of material. Its virtue resides in its fittingness to its purpose.

The Royal Bank of Canada Monthly Letter

(continued from page 35)

of hospital activity where all patients are potential examination and teaching material.

As soon as possible after the discharge of the patient, the case was discussed by the investigator and the medical member of the team. Using the medical case records and the information supplied by the other members of the team, each case was reviewed on its merits and an attempt was made to answer these questions as objectively as possible:

1. Was admission avoidable or did the patient really require a hospital bed?

2. Could the patient have resided in hostel accommodation and have attended the hospital just for investigation and treatment?

3. Does the patient suffer from a chronic illness requiring accommodation in a long-stay hospital bed?

If the patient had been readmitted, it was asked whether this was the result of the previous hospital stay being too short. This was a question considered to be as important as asking whether the duration of stay had been too long.

In summary, it may be said that this study represents an attempt to establish a base-line of utilization of facilities within a hospital to find out how present facilities are being used and how they may be used more effectively despite restrictions on labour, money and available personnel. To this end, a series of objectives has been drawn up and a research model based on findings in a pilot study has been designed to give a 10 per cent random sampling of admissions to the departments of medicine, surgery, paediatrics, obstetrics and gynaecology.

An approach to solving the problems posed in this study lay in the field of "operations research". It was felt that solutions could be obtained most effectively by pooling the knowledge and experience from the various areas on which the study impinged. To carry this out, each department formed a team consisting of the head nurse, medical social worker, and a medical consultant, with the investigator heading each team. It is fully realized that the approach of "operations research" in the hospital setting is something new, but the justification for such research should be obvious to all who are interested in the medico-social welfare of patients.

Speaking on research in patient care*, Lester J. Evans, M.D., director of the Centre for Rehabilitation Services, New York University, has said, "What we are finding out through research in patient care should have significant effects in nursing and medical education. Such research will prove most fruitful in the university and teaching setting. The sources of new knowledge and energy are found in that setting; those who are being trained will be reached in the process; the universities can only fulfill their obligations by becoming involved in patient care research.

"Three principal areas need further research: patient needs—we do not know enough about our patients; sociology of the hospital — it needs to be studied as an instrument of health and medicine; and team-work — the increasing number of health, related professions and sub-professions reflect a better appreciation of the breadth of patient needs, but we have not examined carefully enough who does what, who is the team leader, et cetera."

The collection of data in the main study commenced on April 21, 1960, and ended shortly after April 13, 1961. Coding of the material collected has taken place throughout the survey year and the recording of the data on punched cards began about the middle of April preparatory to the analysis using the I.B.M. equipment. ■

** From an address given at a meeting of the committee on research, National Health Council, January, 1960.*

International Hospital Exhibition in Cologne Next Year

The International Hospital Exhibition will be held in Cologne, Germany, from May 9 to 12, 1962. Organized by the Working Community for German Hospitals, the exhibition will provide a comprehensive survey of hospital construction and fittings, interior installations and equipment for treatment, supply, nursing and administration. It will offer suggestions on the modernization of hospitals, particularly with regard to the heavy demand for trainees and the chronic shortage of staff.

The Electro-Medical and Radiological Exhibition is to be held at the same time as the convention of the German X-Ray Society in the Cologne exhibition grounds, May 6-12, 1962.

Tweny Years Ago

From Canadian Hospital
November, 1941

A Canadian Appraisal of the Celt in Medicine and in Literature

The Celt has long been an interesting figure, whether it be in war or in peace, in science or in finance, in the arts or by the fireside. Not only our literature but our civilization would have been the poorer without the enriching influence of this unique race. Whether he be Irish, Scotch, Mann or other Godhelic, or belong to the Cymric branch in Wales and Cornwall, the Ersian traits are not far submerged.

One of the most delightfully written references to the Celt came from the pen of Dr. E. P. Scarlett of Calgary last year when writing an essay on Oliver St. John Gogarty, the famous and versatile Dublin otolaryngologist and author. Scarlett was led to this comprehending analysis of the Celt by the observation that among the physicians who have wandered from science into the arts, the one with a Celtic background would seem to have been especially favoured.

"There is a natural bridge between the world of Hippocrates and the world of Homer. Rabelais found his way across its arches, and Smollett, and poor Goldsmith. In our time the roadway has been crowded with figures, but the one man in the throng who travels most securely in the great tradition is the Dublin surgeon, Oliver St. John Gogarty. As a figure he represents the diversity of medicine, its faculty as a learned profession for winning distinction in other fields, its eminence in literature. He is a supreme example of the doctor who has turned author to the great benefit of his time.

"It is probably the world of Dublin which has taken Gogarty from medicine to letters, that and the fact that he is a Celt. Now the record of the Celt in medicine is brief but brilliant. On the purely professional side, the Dublin school — Graves, Stokes, Dominic, Corrigan and Colles. In another field Goldsmith and Charles Lever, their vitality breaking the bounds of humdrum medical practice and showering sparks of wit and poetry over their world. For the Celt in medicine is in reality Pan in the consulting-room. To austere medical eyes this is a confusing and grotesque spectacle, but viewed otherwise, it is an altogether exciting and enchanting business. In the Celt we do not find the ordinary simplicities or the ordinary complexities. He is as various a creature as any in folklore. He is the most vital person in Christendom, spendthrift in action and emotion. He has a quick sympathy, a gaiety, and a rich and facile idealism foreign to the English. He wanders down the Via Dolorosa of his history, chanting songs of clashing loyalties and ideals. And whether within the borders of France or in the highlands of Scotland, in the lone shielding of the Hebrides, in Wales or in Ireland, he echoes the ancient curse of the ironies of the things of this world which for him have been woven into a pattern of ill-fortune and tragedy. He alone in the modern world fully grasps the meaning of Virgil's *lacrimae rerum*. His currency is not humour, it is wit touched always with irony and the abiding memory of his country of the spirit, his Tir-na n'Og, a land of dream-twilight haunted by shadows of the past and visions of the future."

Use what talents you possess: the woods would be very silent if no birds sang there except those who sing best. *Henry Van Dyke.*

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we have graduated from being young; our national association is 26 years old. This contrasts with the dietetic profession in France which has been in existence only eight years.[5]

Czechoslovakia has had schools of practical dietetics since 1934 when the first one was founded in Prague and offered two year courses. After the second world war, two new dietetic schools were founded at the medical faculties of Brno and Bratislava offering four year courses. These schools were founded to cope with the more acute need for dietitians, and about 100 dietitians graduate from them every year.[4]

A school of dietetics was established in 1924 at Tokyo, Japan, and the Law of Dietitians was enacted in 1947.[6]

Diet therapy was given prominence in the program of the Congress. Within the framework of discussions and reviews, atherosclerosis gave evidence of being a problem of international interest. Representatives from France, Czechoslovakia, Belgium, U.S.A. and Canada contributed to the discussions.

Lord Amulree of the geriatric unit, University College Hospital, London, England, was the able chairman of an interesting session on the subject of feeding older people. Participating in this discussion were Dame Harriette Chick of the Lister Institute, London; Maurice Gautrelet, Paris, France; and G. F. Jung and K. Jahnke, Dusseldorf, Germany.

The consensus of opinion was that poor feeding habits of the elderly are the direct results of habits formed during youth. Dame Harriette Chick suggested that the elderly should be encouraged to eat meals very slowly as well as to limit the total food intake. Any balanced diet will provide a good selection of vitamins she claimed, but since old people tend to neglect vegetables and fresh fruit, their diet should be supplemented with Vitamin D, particularly in those countries with limited sunshine.[6]

Many old people would welcome Lord Amulree's opinion of stimulants. He has never seen harm from use of tea or coffee in reasonable quantities, and believes alcohol is an admirable drug for those who like it and are used to it. He feels a night cap of whiskey will often be more effective and less harmful than all the barbituate drugs in the world.

Many excellent field trips were organized for delegates. Visits were arranged to several well known London area hospitals for those interested in hospital feeding. School meal organizations welcomed visitors to see different methods and types of meal service. Plant in-feeding arrangements at various commercial organizations were included in the program of professional visits.

From every angle, the Congress program fulfilled its objective as described in the message of the chairman in the foreword to the proceedings of the Congress. Miss D. Hollingsworth (U.K.) said the Congress was designed, through the scientific papers, professional visits and group discussions, to help dietitians in all parts of the world to apply the principles of nutrition in their everyday tasks.

No report of the Third International Congress of Dietetics

would be complete without some mention of the gracious hospitality extended to all registrants. Due to the size of the Congress, all registrants could not be included in every invitation. Her Majesty's Government in the United Kingdom entertained delegates at a reception at Lancaster House where the guests were received by Miss Edith Pitt, O.B.E., M.P., Parliamentary Secretary to the Minister of Health. After the Congress proceedings had been adjourned officially, we were entertained at a delightful reception by the London County Council.

The Congress dinner, held at the Savoy Hotel, was an interesting experience. Prior to the dinner, the menu had been printed in one of the newspapers and the caloric content of each menu item was given in an article entitled, "Now about this food shortage." The menu did not exhibit any shortage of food or calories. To most of us, the presence of an official toastmaster in a scarlet jacket was an unusual and interesting feature. It was the toastmaster who announced dinner and called on the chairman, Lord Boyd Orr, to propose the Toast to Her Majesty after first admonishing the gathering with "Pray Silence."

In four years' time the Fourth International Congress of Dietetics will be held in Stockholm, Sweden. The invitation of the United States of America has been accepted for 1969 when the Congress will meet on this side of the Atlantic.

References

1. Countries represented at Congress: Australia, Austria, Belgium, Brazil, Bulgaria, Canada, Ceylon, Chile, Czechoslovakia, Denmark, Dominican Republic, Fiji, Finland, France, Germany, Ghana, Greenland, Guatemala, The Netherlands, India, Iran, Republic of Ireland, Italy, Japan, Malaya, New Zealand, Nigeria, Norway, Poland, Portugal, South Africa, Sweden, Switzerland, Turkey, United Arab Republic, U.K., U.S.A., U.S.S.R., Federation of the West Indies, Yugoslavia.
2. *Education and Occupations of Dietitians in Germany*, H. D. Cremer, Giessen, West Germany.
3. *Orientation et Développement de la Profession de Diéteticien en France*, Jacqueline Farquet, Paris, France.
4. *Education in Dietetics in Czechoslovakia*, P. Dobersky, Prague, Czechoslovakia.
5. *Education of Dietitians and Its New Trend in Japan*, Sagao Nakajima, Hyogo, Japan.
6. *Nutrition for the Elderly*, Dame Harriette Chick, London, England.

Trustee Institutes in Two Atlantic Provinces

The Prince Edward Island Hospital Association held its first institute for trustees last September 21. Judge J. S. Desroches, president of the association, presided as chairman. The 60 registrants consisted of trustees and representatives of the medical and administrative staffs of the Island's hospitals.

The program was presented in four parts which dealt with the changing aspects of trustee responsibility. In addressing the delegates, Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association emphasized the extent of the trustee's responsibility. Since the board of trustees legally has the final responsibility for the operation of the hospital, he said, it deals not only with material things but also with the health of fellow citizens.

Other topics discussed were the desirable size of the hospital board, selection of board members, board committee function, the board meeting and the changing rôle of the trustee under national hospital insurance. Other special speakers were the Hon. Hubert B. MacNeill, M.D., provincial minister of health; W. I. Taylor, M.D., executive director of the Canadian Council on Hospital Accreditation; and Lawrence L. Wilson, assistant director of the Canadian Hospital Association.

A similar institute for trustees was held under the auspices of the Nova Scotia Hospital Insurance Commission and the Nova Scotia Hospital Association in Halifax, September 19-20.

For Hospital Orderlies

A training program for male nursing assistants — orderlies — has been arranged by the Canadian Vocational Training School in Saskatoon, Sask. This will be a ten-month course—14 weeks at the School and 26 weeks in an approved hospital. The course directors will select well qualified applicants for the first course which will begin in January of next year. Selected candidates will receive a living allowance of about $60 per month for the full training period.

Applicants must be over 18 years of age, have completed grade nine successfully and have good personal references. Applications should be mailed to the principal of the School, E. A. Davies, Saskatoon, Sask.

Hospital in Northern B.C. Has Interesting History

Construction of a new 100-bed hospital has begun in Fort St. John, B.C. The existing Providence Hospital was opened in 1931, and from the beginning its history was colourful. Before the opening of the hospital a man from Rose Prairie limped into the doctor's office with some of his toes partially cut off. The doctor performed a difficult operation without an anaesthetic. Instances like this showed the need of a hospital north of the Peace River.

Around 1930, there was very little concentration of population at Fort St. John, and the hospital board members had to make trips over rough roads to solicit the help of the scattered settlers who responded by cutting and hauling logs to the local mill, making lumber and donating labour in the construction of the hospital. When the new building was turned over to the Sisters of Charity of Providence in 1931, there was very little money. A public-spirited citizen used to drive two of the Sisters about the country to ask for help in whatever way the farmers could give it — whether firewood, chickens, meat, or a sack of potatoes. These essentials kept the hospital going and eased the burden of the Sisters who had to find cash for other things such as medical supplies. During the construction of the Alaska highway, additions were made to the building, and later an outside heating plant was built to lessen the fire hazard. Then in May, 1961, the roar of a bulldozer heralded the beginning of construction on a long-awaited new hospital.

Brucelea Haven at Walkerton Opened

The new addition to the Home for the Aged at Walkerton, Ont., called Brucelea Haven, was opened last month. Facilities for approximately 100 additional residents have been provided in the new wing which consists of two floors and a partial basement. (See *Canadian Hospital*, April, 1960.)

The home has been designed for three types of patients—those who require a special degree of supervision, those who require some degree of assistance and are not capable of moving about without assistance, and those who are fairly independent and can move around on their own. Eventually the old main building, which is over 50 years old, will be removed to make way for a new wing.

The Royal Canadian Legion will look after the chapel which is adjacent to the Home and which can be used for services and also as a quiet room where the residents can sit and meditate.

Upkeep Team Provides Patient Entertainment

The "upkeep team", an unusual room service unit of the maintenance department at Massachusetts Memorial Hospitals, was developed for the first Mr. Fixit who made the rounds of patient rooms alone. The team now comprises four pleasant, white-clad experts, each with his own rolling work bench: an electrician, a painter, a carpenter-mechanic and a plumber. Unless a patient is acutely ill, the chance to lie comfortably in bed and watch a repair job in progress is a pleasant break in the day, and an indulgence to the "sidewalk superintendent" that exists in all of us.

Housekeepers
(continued from page 60)

ing and reports; (c) general cleaning methods for floors, walls, windows and equipment; (d) budgets; (e) inter-departmental relations; (f) linen control and distribution; (g) bacteriology; (h) isolation techniques; (i) communicable diseases; (j) principles of sanitation; and (k) union agreements.

2. *Practice.* This portion consists of extensive on-the-job training and experience as housekeeping supervisors. The executive housekeeper sees his trainees daily, and each week a group conference is held at which all matters affecting the department are discussed and group participation in the thrashing out of these problems is encouraged. The supervisors periodically present short discourses on pertinent subjects to encourage the trainees in the art of public speaking.

To facilitate the training, the hospital is divided into seven sections — the housekeeping office, three different ward areas (encompassing seven wards each) plus adjacent departments, the nurses' residence, and special services such as wall washing, garbage removal, elevators and linen control and distribution. The trainees rotate through all seven areas and are responsible for the supervision of each of these sections for periods of approximately three months. Each has jurisdiction over some 40 people and is responsible for the complete housekeeping and related activity of each area.

3. *Correspondence Course.* This is part of the training program and is conducted with the assistance of the National Sanitary Suppliers Association.

Throughout the training period, use is made of written examinations, films, slides, tape recordings and guest lecturers. After 20 months of training and experience, these graduates should be capable of assuming the job of housekeeper without any difficulty in any hospital of medium size (200 beds). One or two could easily attain the position of executive housekeeper in some of our larger hospitals.

The Hamilton General Hospitals expect to lose these trained housekeepers eventually, but the hospitals will still benefit by having interested, efficient personnel for two years and by providing a service to hospitals in general.

With the graduation of the second group in late 1961, the future of the course still remains uncertain. It has placed an exceptionally heavy burden on the executive housekeeper and it is my feeling that one cannot conduct a good training program and remain a good housekeeper at the same time in a hospital of this size. One aspect will, of necessity, be neglected. A possible solution for these hospitals would be to obtain a course supervisor, who would be responsible to the executive housekeeper, but to whom would be delegated responsibility for the training program and a continuing in-service educational program for all housekeeping personnel. Another difficulty facing any one hospital conducting a course of this nature, and the Hamilton General has experienced it, is the problem of attracting men and women who are sufficiently interested in the housekeeping field and have an aptitude for management.

The Ontario Hospital Association and the Canadian Hospital Association have become increasingly interested in this course and are trying to find ways to adapt it so that it might be available for all hospitals in Ontario and, eventually, in the country on a nation-wide basis. The latter would seem to be the most feasible solution and worthy of serious consideration. The program might be patterned after the central nursing schools with a centralized instruction program followed by practical experience in selected hospitals. The centralized theoretical part should not pose too many problems, other than time off from a hospital job to attend. The unique feature we have introduced, whereby theory is made concurrent with practical application, is the main stumbling block. This difficulty, however, should not deter us from finding a solution to the major problem of hospital housekeeping today *i.e.*, the deplorable lack of adequately trained housekeepers. Administrative interest and concern in the housekeeping field in general, and in the training of executive housekeepers in particular, must become even more widespread in the years to come. ■

The world is merely a bridge; ye are to pass over it, and not to build your dwellings upon it.—*Inscription on the Victory Gate, Fathepur, India. From Agrapha, Unwritten Sayings of Jesus.*

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 25 Imperial St., Toronto 7, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch of fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement—$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

MEDICAL RECORDS LIBRARIAN

As Assistant in modern 250 bed hospital (open in 1956). Situated in the Nickel Capital of the world, population over 75,000.

Excellent employee benefits, pension plan, etc. Salary open.
Apply to:

The Administrator,
SUDBURY MEMORIAL HOSPITAL,
Sudbury, Ontario.

REGISTERED MEDICAL RECORDS LIBRARIAN WANTED

to assume the responsibility of the records department in a 163-bed general hospital. For further particulars, please reply to:

Administrator,
Kirkland and District Hospital,
Kirkland Lake, Ontario.

DIRECTOR OF NURSING

For active general hospital (50 beds) with full complement of services: Building completed February 1961: Operating Room Supervision experience essential.

Salary commensurate with qualifications and experience.

Apply, giving full particulars of training, etc.:

Administrator,
Kimberley and District Hospital,
Kimberley, B.C.

Dietitian Required

Professional Dietitian required to assume responsibilities of dietary department in a 163-bed general hospital. Salary commensurate with experience. Please reply to: Administrator,

Kirkland and District Hospital

KIRKLAND LAKE, Ontario

DIETITIANS REQUIRED

Director of Dietetics and Qualified Dietitians for 450-bed accredited hospital. Large Student School. New and modern Dietary Department, cafeteria and trayveyor service. Salary commensurate in accordance with C.D.A. recommendation. Day shifts only. Liberal holidays, sick leave, pension plan and other perquisites. Excellent working conditions and quarters prevail. Transportation refundable after six months.

Apply Superintendent,
McKellar General Hospital,
Fort William, Ontario.

ADMINISTRATIVE ASSISTANT

Sister hospital requires administrative assistant to work directly with administrator in the formulation and revision of certain hospital policies and procedures. Should be capable of assuming complete responsibility for various administrative functions. Hospital experience essential. This is a temporary position for a minimum of two years. Excellent opportunity to gain valuable practical experience in the administration of a medium size hospital. Reply, stating qualifications, availability and salary expected, to

Box 10355,
Canadian Hospital,
25 Imperial St., Toronto 7, Ontario.

DIRECTOR OF NURSING

For modern 103-bed general hospital opened in 1959 in metropolitan area of Vancouver. Please apply first by letter giving full details of training, experience, qualifications and salary requirements to:—

Administrator,
SURREY MEMORIAL HOSPITAL
13750—96th Ave.
North Surrey, B.C.

PHARMACIST REQUIRED

By Orillia Soldiers' Memorial Hospital, please apply by letter outlining qualifications, experience, and salary required to:

WM. A. HUME,
SUPERINTENDENT

Orillia Soldiers' Memorial Hospital, Orillia, Ontario

CHIEF DIETITIAN

We require a qualified dietitian, with membership in the C. D. A. to head a modern dietary department. Hospital is situated in the cultural and historic city of Kingston. Kingston General Hospital has 600 beds, is fully accredited and has a nurses' training school.

Excellent personnel policies with 4 week's annual vacation, pension and medical plans. For further information, address enquiries to the Superintendent. Please include details of past experience.

KINGSTON GENERAL HOSPITAL
Kingston, Ontario

Registered Medical Record Librarian

As chief librarian and as assistant to department Director. Excellent opportunity for successful applicant. Good salary, pension plan, group life and other employee benefits. Please apply in writing giving full particulars of age, background and experience in first letter to:

The Associate Director
THE HOSPITAL FOR SICK CHILDREN
555 University Ave., Toronto 2, Ont.

Conference of Pharmacists for Emergency Health Services

Pharmacists from the retail, hospital and government fields in Canada met at the Civil Defence College, Arnprior, Ont., from October 16-20, to study and recommend methods by which they might assist Emergency Health Services, Department of National Health and Welfare, in the provision of health supplies and trained man-power in time of national emergency.

The conference was conducted under the supervision of J. Earle Matthews, pharmaceutical consultant and administrator, Health Supplies Section of the Emergency Health Services, in cooperation with the staff of the Canadian Civil Defence College.

Approximately 60 delegates attended the sessions which combined a three-day civil defence refresher course with a two-day study of the health supplies officer's rôle.

Fear not that thy life shall come to an end, but rather fear that it shall never have a beginning. *Cardinal Newman.*

C. H. A. Library is for your use

THE purpose of the Canadian Hospital Association library is to be of assistance to the personnel in Canadian hospitals. In addition to a fine collection of books, manuals, and pamphlets, the library maintains files of articles clipped from current journals on subjects pertaining to the various aspects of the hospital field. Packages are made up in accordance with specific requests. All material is available for a three-week loan period. There is no charge for this service. These packages are authorized as third-class matter and may be returned to the librarian at the rate of 2c for the first two ozs. or fraction thereof and 1c for each additional two ozs. or fraction thereof, or at the parcel post rate, at the option of the sender.

SUPPLIERS TELL US—

Interesting items from the news releases of hospital suppliers

by C.A.E.

Mil-Ko Products to Sell Through Food Brokers

Mr. R. Brown, sales manager of Mil-Ko Products, recently completed the changing over from their own sales staff to food brokers throughout Canada. A. H. Sainsbury & Co. Ltd. will be responsible for distribution in Ontario of Instant Mil-Ko, Chocolate Mil-Ko and the new Mil-Ko 8, which is a partly skimmed milk powder with butterfat.

While food brokers will be responsible for the sales and distribution of Mil-Ko products at the store level, Mil-Ko will still retain their own residents men throughout Canada, who will work closely with food brokers in each district. Key men are Gerald Brock of Hamilton, who as sales promotion manager will work across Canada, Alan Atkinson in Vancouver, R. G. Mitchell in Montreal and Gordon Goodrow in Hamilton.

New Thermo-Fax Paper Makes White Address Labels

A new white gummed and perforated Thermo-Fax Copy Paper on which master address lists can be automatically copied has been announced by the Business Communications Division of Minnesota Mining and Manufacturing of Canada Limited.

Designed for such use as addressing direct mail pieces, letters, literature, anywhere a repeat mailing list is used — the new No. 434 White Paper makes errorless, completely dry copies ready for immediate use. The master list is retained in the file for unlimited use.

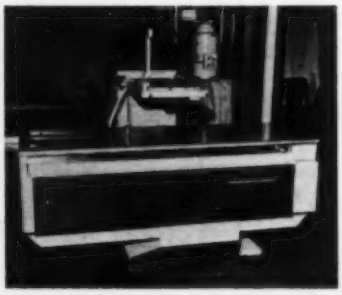
When a mailing is to be made the master list, on ordinary typing paper, is placed on top of a sheet of the new white, gummed and perforated copy paper and inserted in any Thermo-Fax Copying Machine. An exact copy of the original full page emerges in approximately four seconds. Labels are then separated and applied to mail, completing the operation. The paper is designed for use either as a complete mailing system or as a supplementary function of an existing program.

The new white label paper No. 434 is available in two sizes — 8½ x 11 and 8½ x 14. Standard size labels are 2⅞" x 1".

More information may be obtained by writing the Business Communications Division of Minnesota Mining and Manufacturing of Canada Ltd., Post office Box 757, London, Ontario.

RCA Victor Introduces New Keleket X-Ray Tables

A new line of diagnostic X-ray tables has been introduced by RCA Victor Company, Ltd., distributors of Keleket X-ray equipment in Canada.



The tables are the Keleket Nova-Matic 90°-90°, and 90°-15°. Both are trim and modern in their appearance, entirely practical in their design. For extreme rigidity, both tables are supported from either side, not cantilevered; both have unique features and a range of fully-powered movements to enable them to fulfill every conceivable radiographic and fluoroscopic requirement.

The Nova-Matic models are true "island" tables, identical front and back and free of any obstruction. This important feature is achieved by means of a ceiling-supported tunnel and tower that can be simply detached and swung out of the way. This arrangement also reduces table weight by almost 400 lbs., and halves the effort needed to move the fluoroscopic assembly.

In addition to table tilt through 90°-90° and 90°-15° respectively, the Keleket tables offer lateral, longitudinal and vertical movements. These are optional, to allow radiologists to tailor the table to their specific needs. The table top can have a longitudinal movement of up to 30 in. each side of centre; and lateral movement up to 6 in. each side of centre.

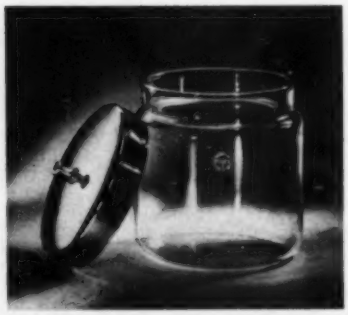
For complete details, contact the Technical Products Division, RCA Victor Company, Ltd., 1001 Lenoir Street, Montreal, Quebec.

Pyrex Jars from Mercer Feature Innovations

Hospital jars made from Pyrex brand glass are now being made available to hospital supply houses at attractive prices by Mercer Glass Works, Inc., of New York City.

These Pyrex jars are made exclusively for Mercer by Corning Glass Works. The glass resists autoclaving temperatures up to 540 degrees C. without discolouration or devitrification, and the jars will not crack or break when subjected to abrupt temperature changes. Walls are uniform in thickness and the surfaces are entirely free of mold marks, assuring unusual clarity. All rims are heavily beaded, thus making them highly resistant to chipping.

The walls of these jars meet the bottoms in a gentle curve instead of a sharp right angle, and thus simplify inside cleaning and completely eliminate dust and dirt accumulations.



(continued on page 108)

When every second is vital...

You Know Linde Oxygen is at Your Fingertips!

Why? Because Linde has been providing medical oxygen and oxygen therapy services to hospitals for over 40 years. Linde delivery methods and facilities are based on long experience . . . they're designed for absolute dependability under the most critical situations.

Add to this the most comprehensive oxygen therapy services provided by any oxygen supplier—bulletins on the latest advances in oxygen therapy, current films on oxygen therapy techniques, hypoxia and others, the organization of nurses clinics—a wealth of up-to-date information at your service at no cost to you.

More important to administrators is Linde's technical service. For pipe line layout, planning, design, Linde Oxygen Therapy Consultants are available for technical assistance. When you are adding a new wing, planning a new hospital, or updating present facilities, call Linde for experienced technical advice.

What about supply systems? Linde pioneered liquid oxygen storage in Canada. Since then they have developed hospital supply systems to meet every need. Cylinders—Cascade—Driox liquid storage—a unit to suit your requirements. Storage units which can be modified as your needs increase with future expansion.

Learn the full story of these tangible advantages from your local Linde Oxygen Therapy Consultant. Why not call him now, or write Union Carbide Canada Limited, Linde Gases Division, 123 Eglinton Avenue East, Toronto 12, Ontario.

Canada's leading supplier of medical oxygen, oxygen piping systems and equipment.

UNION CARBIDE **LINDE GASES DIVISION**

"Linde," "Cascade," "Driox" and "Union Carbide" are trade marks.

Suppliers Tell Us—

(continued from page 106)

For full details and illustrated price list, write Mercer Glass Works, Inc., 725 Broadway, New York 3, New York.

Physicians' Record Card Frames for Record Cards

Convenient filing units (Cardex) for nursing care cards and similar hospital, business, and medical records forms are described and illustrated in a recent circular now available from the Physicians' Record Company.

The card holders are suitable for nursing stations, hospital and nursing home offices, and physicians' records. Bound Card Frames, Visible Card File Books, Pocket Portfolios, and other portable card files may be used for 8″ x 5″ and 6″ x 4″ card records.

Nursing Care Cards for patients' medical records are also described.

Write to the Physicians' Record Co., 3000 South Ridgeland Ave., Berwyn, Illinois, requesting "Circular 1617-B."

Pioneer Chart Illustrates "Closed Gloving Technique"

Steps describing the new "closed gloving technique", an approved method of donning sterile gloves over hands and gown cuffs, have been incorporated into a wall chart by The Pioneer Rubber Company, manufacturers of famous Rollpruf surgical gloves.

The chart is available upon request from the Company or its representatives. It includes photographs of the 14 steps involved in the new gloving procedure, arranged effectively on a 17″ x 22″ chart. Easy-to-read, concise directions caption each of the photographs, which illustrate the gloving procedure.

The new "closed gloving technique" is the most recent development to receive wide acclaim as a most sterile and suitable procedure of donning gloves prior to surgery. Its benefits include the reduction of the possibility of contamination of the inner surface of gloves and hand areas; a decrease in the use of powder in the gloving procedure, and a reduction of powder dust in the air; savings in teaching time; elimination of unnecessary steps in gloving, and less stress and strain on gloves to provide added savings for the hospital.

A free copy of the chart can be obtained by writing directly to The Pioneer Rubber Company, 396 Tiffin Road, Willard, Ohio.

Royal Metal Introduces Fully-Automatic Hospital Bed

Royal Metal Manufacturing Company Ltd. have recently introduced the new Royal-Matic Hi-Lo Bed, a trouble-free, fully automatic, power-operated hospital bed.

The Royal-Matic Hi-Lo Bed incorporates many advanced performance features that are new, it is said, to the power-operated hospital bed. Principal among these features is the quiet gentle hydraulic action which permits smooth adjustments of bed ends and spring sections. These movements are so gentle that a patient's position can be changed while sleeping.

Twin control units allow completely individual adjustments of bed ends and spring sections, by a simple press-button process. Either the nurse or the patient can adjust the bed for all positions, with the amount of control permitted to the patient being at the discretion of the doctor or nurse.

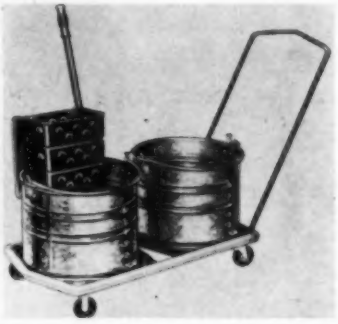
Another exclusive feature is the centre post construction of the bed pedestals, which contain the hydraulic piston mechanism. This single central telescoping action eliminates all chance of "rocking" when raising or lowering the bed, unlike the conventional four-legged type of adjustable-height hospital beds.

The Hi-Lo bed is sold exclusively by Simpson's Contract Division through their branches coast-to-coast.

For further details write to: Royal Metal Manufacturing Co. Ltd., Galt, Ontario.

Colson's New "Moppet" Line of Floor Cleaning Equipment

Colson's Moppet Line, a complete range of economy-priced floor cleaning equipment, is now ready for distribution by Colson (Canada) Limited. The Moppet Mop Set, shown here, is a complete pack-



age — two 8¾ gallon buckets for washing and rinsing, and mop wringer, on an adjustable platform dolly for secure bucket mounting. Dolly has push-pull handle, 3-inch Colson non-marking wheels, and full non-marking wrap-around bumpers.

The portable wringer and buckets are available as separate units, the buckets (called Measurette tanks) being then equipped with their own specially fitted dollies. Tanks are sturdily constructed of fully galvanized reinforced steel, and clearly marked with embossed numbers to ensure accurate preparation of cleaning compounds.

The Wringrite wringer will handle all mops from 12 to 32 ounces; with a ratio of 20 to 1, the wringer's single action lever provides pressure both laterally and downward on mop surfaces. All wringers are equipped with a series of splash-proof drain louvres.

Full information about prices and delivery from Colson (Canada) Limited, 123 Oakdale Road, Downsview (Toronto).

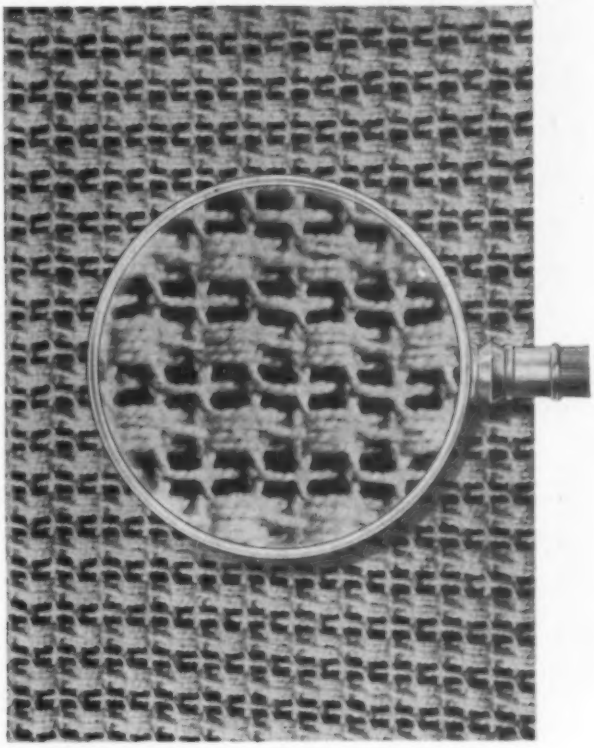
New Product Removes Ice From Windshields

G. H. Wood & Company Limited advise their new product, Wood's Ice-Off, removes ice from windshields, windows, locks and headlights—a boon to the busy physician and executive.

(concluded on page 110)

Tex-made SANI-WEAVE

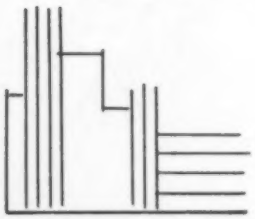
A NEW BLANKET FULL OF HOLES!



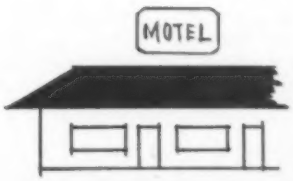
A 100% cotton cellular blanket woven on the honeycomb principle providing hundreds of tiny air pockets that trap heat and hold it. This Tex-made Sani-Weave blanket is the answer to Canadian hospitals' cross-infection hazard.

- Can be sterilized by boiling
- Launders with a minimum of shrinkage
- Provides warmth without weight
- Static free
- Economical and durable
- 9″ selvedge edge
- 78″ x 96″

Other lengths available upon request subject to a minimum quantity.



HOSPITALS



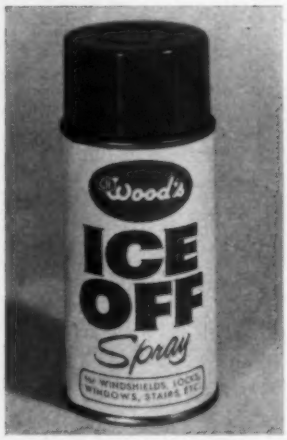
HOTELS & MOTELS

DOMINION TEXTILE CO. LTD. MONTREAL

Suppliers Tell Us—

(concluded from page 108)

No more scraping windshields and windows in zero weather! No more thawing out frozen locks with a cigarette lighter! Just reach for a can of Wood's new Ice-Off, press the finger tip control, spray the ice, and the ice is gone.



Wood's new Ice-Off comes packed in a handy full 10 oz. can to fit all glove compartments, and leaves all glass surfaces clear and film-free to assure safe vision.

Further details may be obtained from G. H. Wood & Company Limited, Household Products Division, Box 34, Toronto 18, or any G. H. Wood & Company Branch across Canada.

New Portable Dictating Transcribing Unit

A new addition to the Stenorette family of magnetic dictating machines — a portable unit powered by dry-cell batteries and with dictating and transcribing accessories—has just been introduced by DeJur of Canada Limited, marketers in Canada of the DeJur-Grundig line of dictating equipment.

Called the Stenorette-Versatile, this unit runs on penlight size mercury cells that have a life expectancy of better than 50 hours. Users can obtain up to 45 minutes of continuous dictation on each reel or magazine of magnetic tape; these tapes are interchangeable and compatible with tapes used on all standard desk-top Stenorettes. Owners of Stenorette equipment can dictate on their portables away from the office, mail their tapes to the office for transcription on the standard Stenorettes, or transcribe directly from the portable unit, whichever is more convenient for them.

For additional information contact Business Equipment Division, DeJur of Canada Limited, 184 Bay Street, Toronto 1.

Honeywell Controls Transfers Gerard Brogan to Halifax

John F. Bertram, eastern region manager, Honeywell Controls Limited, has announced the transfer of Gerard Brogan to the company's Halifax office.

Gerard Brogan

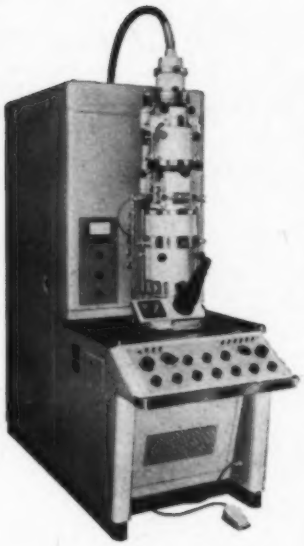
Mr. Brogan will be responsible for commercial division sales coverage of the Atlantic provinces. He joined Honeywell in 1959 as a commercial division sales engineer in the Montreal office.

Mr. Brogan is a graduate of the Wigan Technical College, Wigan, England. He is a Corporate member of the British Institute of Radio Engineers.

Be nice to people on your way up because you'll meet them on your way down.

It is not true that suffering ennobles the character; happiness does that sometimes, but suffering, for the most part, makes men petty and vindictive.

Somerset Maugham



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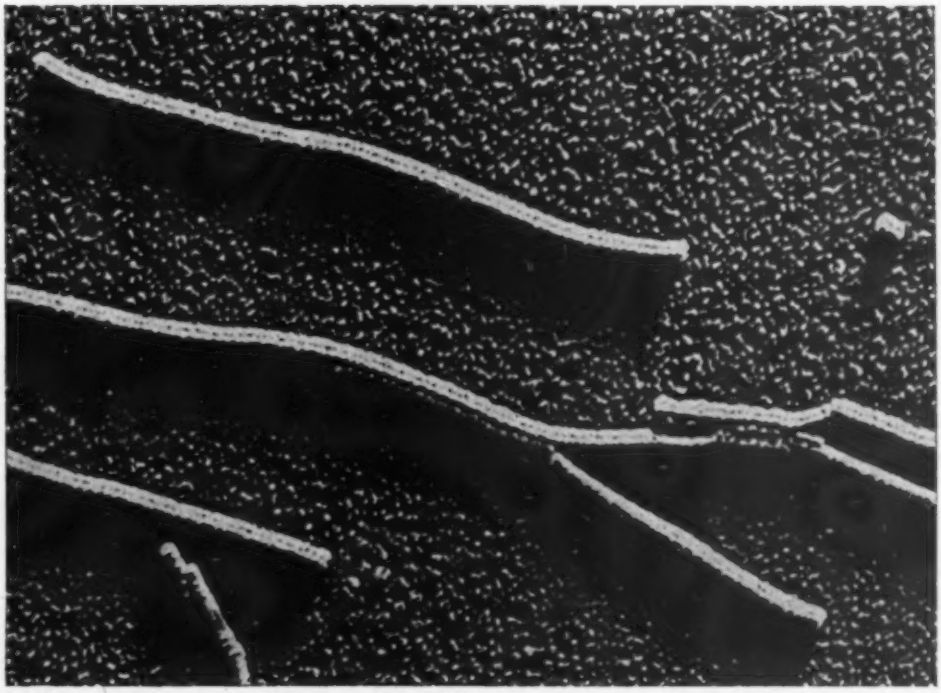

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